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ABSTRACT

Intended as guides for planning rehabilitation facilities, the six volumes treat respectively: (1) a comprehensive center or a unit in a hospital, (2) services for the mentally ill, (3) services for the mentally retarded, (4) work-oriented facilities, (5) services for the blind and visually impaired, and (6) services for individuals with speech and hearing impairments. Such topics as approaches to planning, the various types of services and facilities, the groups to be served, staffing, the physical plant, and equipment are discussed. (JK)

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THE COMPREHENSIVE REHABILITATION CENTER
A REHABILITATION UNIT IN A GENERAL OR SPECIAL HOSPITAL
GENERAL ARCHITECTURAL PRINCIPLES FOR REHABILITATION FACILITIES

IDEAL SERVICES SERIES

VOLUME I

BY

ROY M. HOOVER, M.D.

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FOREWORD

It has been the philosophy of the Division of Vocational Rehabilitation in Florida that some services for the disabled can best be provided by encouraging community participation in the development, expansion, and control of workshops and rehabilitation facilities. In order to engender and facilitate community planning and action, the Workshops and Rehabilitation Facilities Planning Project staff has completed a survey of facilities, a study of the prevalence of disability, and a list of resources. These materials should aid local planning groups in answering the following questions: What facilities exist in the community? How big is the problem? What help is available in meeting the needs of the disabled?

This guide for ideal rehabilitation facilities is resource material which may help communities in planning for rehabilitation facilities. It is also designed to emphasize (1) the multi-disability approach as opposed to the single-disability approach; (2) the provision of services for all age groups; and (3) a description of specific services which might be provided in a comprehensive center or in a rehabilitation unit located in a general hospital. It describes inpatient facilities.

This guide is not a standard that has to be followed. Its purpose is not to communicate what a community must have in the way of facilities and services, but to describe the type of services that ought to be considered by the community in the development of a rehabilitation facility.

This particular volume presents only "A Comprehensive Rehabilitation Center," "A Rehabilitation Unit in a General Hospital or Special Hospital," and "General Architectural Principles for Rehabilitation Facilities." Each of these Chapters is an entity within itself; therefore, there may seem to be some duplication from chapter to chapter. Similar guides concerning work-oriented facilities, rehabilitation services for the mentally retarded, mental health rehabilitation services, rehabilitation services for the blind and visually impaired, and rehabilitation services for speech and hearing impairments have been published.

Roy M. Hoover

ABOUT THE AUTHOR

Roy Hoover, M.D., attended medical school at the University of Virginia. After a residency at New York Orthopedic Dispensary and Hospital, he began private practice in Roanoke, Virginia. He began working at the Woodrow Wilson Rehabilitation Center in Virginia in 1947 and was in charge of orthopedic services for ten years. Then he became Director of Medical Services and served in that capacity until his retirement in 1966. Since that time he has resided in Tallahassee, Florida.

Dr. Hoover is a diplomate of the American Board of Orthopedic Surgeons. He has been a member and president of the American Board for Certification in Prosthetics and Orthotics and is a member and past president of the Committee on Prosthetic, Orthotic Education of the National Academy of Science, National Research Council. Dr. Hoover also belongs to numerous other professional organizations, among them the American Academy of Orthopedic Surgeons, American Medical Association, Virginia Orthopedic Society, and the Medical Society of Virginia. He is an honorary member of the Florida Orthopedic Society and the Tri-County Medical Society of Florida.

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The panel of consultants for the Florida Division of Vocational Rehabilitation has made many helpful suggestions related to the guide. These consultants and their fields are: J. Robert Campbell, M.D., Neurology, Tampa; James G. Foshee, Ph.D., Director, Division of Mental Retardation, Tallahassee; Charles M. Grigg, Ph.D., Institute of Social Research, Florida State University; Donald A. Halperin, Ph.D., College of Architecture and Fine Arts, University of Florida; Stanley I. Holzberg, M.D., Psychiatry, Coral Gables; W. B. Gaines, Consultant for the Blind, Atlanta, Georgia; L. C. Manni, M.D., Respiratory Diseases, Division of Vocational Rehabilitation, Tallahassee; L. Burton Parker, M.D., Physiatrist, Orlando; L. L. Schendel, Ph.D., Speech and Hearing, Florida State University; and Charles Smith, M.D., Orthopedics, Pensacola.

CHAPTER I
THE COMPREHENSIVE REHABILITATION CENTER

A. INTRODUCTION

A comprehensive rehabilitation center is organized and planned to meet the rehabilitation needs of severely handicapped persons, particularly those with orthopedic impairments, since few facilities provide adequate services to meet their needs. The center offers services to the severely disabled because there are usually no other facilities available to meet all their physical restoration, personal, social adjustment, and vocational evaluation and training needs. Nevertheless, many less disabled persons can also be rehabilitated more completely and effectively in such a setting. A comprehensive center serves clients with varied physical, mental, and emotional disabilities. The term "comprehensive rehabilitation services" includes all the services needed to prepare the individual to assume his role in society as a normal participating and productive individual. The degree to which a disabled person is able to participate is determined by his remaining abilities and capacities. All the services required to develop his mental, social, vocational and physical potentials to a maximum functional level should be available.

Among the individuals requiring comprehensive services are those whose impairments render them unable to carry out some or all of the activities of daily living and self-care and thus make them dependent on others, both personally and financially. In the comprehensive center the disabled person is brought to his maximum degree of personal independence; he is trained for a suitable vocation and encouraged toward personal and social adjustment, self-respect, and self-support. Rehabilitation is incomplete until the individual is fitted into his place in society. Our society is work oriented, and in most cases successful rehabilitation leads to competitive employment or homemaking. For the most severely disabled, a maximum degree of self-care is an acceptable goal. Even in cases where complete self-care is impossible, the person may be trained in a suitable vocation and placed in remunerative employment. He may become self-supporting and even support his family. In order to attain such goals as these, the center should provide thorough psycho-social, physical, and work evaluations; physical restoration; counseling; vocational training, recreation; job placement; and follow-up services.

Clients should include both those living in the center and those living at home or in residential accommodations other than the center. These clients may be ambulatory or in wheelchairs. The blind and visually impaired may benefit from special mobility, communication, and vocational training in the comprehensive center. Persons in the center should be of multiple and widely varied disabilities. The disabled person's ultimate adjustment may be more satisfactory if he has been trained in an environment including many other disabled persons and persons with various types of disabilities. Heart, stroke, and cancer cases have particularly great difficulty in adjusting to their disabilities, and this multi-disability environment may be very helpful to them in achieving realistic adjustment and desirable attitudes toward their disabilities.

B. SERVICES OFFERED

1. Case Finding and Referral Services

A large proportion of the cases should be referred by Vocational Rehabilitation field counselors. This type of referral is desirable, because the counselors could offer the center complete work, social, and economic information at the time of admission. A knowledge of the work history and the community and family background are most important in understanding the vocational, social, and personal problems of the client during the time of the evaluation and training. The counselor's involvement in a case is vital in securing prompt, adequate training and suitable employment. The counselor also has a major role in follow-up work.

Referrals can be expected from physicians, hospitals, clinics, schools, welfare agencies, Workmen's Compensation, insurance carriers, visiting nurses, private health-oriented agencies, and clubs. More consistent and complete pre-admission information, as well as adequate placement and follow-up, can be expected if these referrals are channeled through a knowledgeable rehabilitation counselor.

2. Evaluation

a. **Work Evaluation** — Work evaluation includes work sampling, simulated tasks, and job try-outs, and these may continue over a considerable period of time. The physical capacities, interests, and suitability of the client for a given vocation are explored through specific techniques.

This should be a comprehensive evaluation and should determine the vocational potential of the person, the nature of his physical impairment, his educational level, mental ability, and social and environmental background. The comprehensive center should be able to evaluate the illiterate and mentally retarded as well as the person with average education and mental ability, or the individual who is highly educated and brilliant. The evaluation should not be limited to the training possibilities offered by the facility.

b. **Psycho - Social Services** — Information regarding socio-economic, community, and family background should preferably be secured before admission and be available when evaluation starts in the facility. The best sources of such information are through the referring rehabilitation field counselor or through social workers.

The work of the clinical psychologist is very important, and he should be vocational rehabilitation oriented. He administers various tests to determine the mental ability, skills, aptitudes, and interests of the client. Proper interpretation and application of the results of these tests is necessary in arriving at meaningful conclusions regarding the subject's rehabilitation potential and most appropriate field of training or employment.

c. **Medical Evaluation** — A general physical examination and sometimes specialists' evaluations will be needed. In some cases laboratory tests and X-rays also will be needed.

3. Rehabilitation Counseling

The rehabilitation counselor in the center has the responsibility of coordinating the evaluation unit and arriving at vocational recommendations for the client. These recommendations are based on the findings of various phases of the evaluation: educational level; physical abilities and limitations; information developed regarding interests, aptitudes, and potential skills; and the types of employment available in the client's community.

The rehabilitation counseling staff assists the client in personal adjustment to his disability, to the people around him, and to his family. Support and encouragement is of major concern in counseling the client. Counseling is offered in regard to a realistic vocational program; and when the training program is approaching completion, the client is given help in planning for employment. The counselor in the center cooperates with the home field counselor in securing suitable employment for the client. The rehabilitation counselors are responsible for periodic progress reports to the center's staff, especially in regard to personal adjustment and the rate of improvement during the course of training and employment.

4. Physical Restoration Services

There are many types of physical restoration services, and, depending on the specific needs of the client, they should be designed to render him as nearly normal as possible. The following services are planned to minimize physical disabilities and to develop residual abilities to an optimal level.

a. **Medical** — A general physical examination, and when indicated, examinations by specialists, are necessary to determine physical capacities and limitations. Clinical laboratory examinations and x-ray studies should be made if needed.

b. Non-surgical

(1) Medications — Special medications are needed in certain conditions such as diabetes, epilepsy, and mental illness. In these cases the medication may be absolutely essential for the effective functioning of the individual. It is necessary to maintain constant supervision to be certain that medication is taken as directed. In some cases the medication may have to be administered by medical personnel. Appropriate laboratory tests should be carried out at regular intervals to assure the adequacy of the medical treatment.

(2) Nursing — This is an important part of the medical care. It varies from complete care (including feeding, dressing, and all the functions that are normally carried out by the individual) to merely supervising the patient in carrying out learned skills. The nurse gives invaluable assistance to the patient in helping him understand his problems and realize the importance of constant and permanent care to avoid the development of serious complications. Nursing is especially important in cases of spinal cord injury and other severe physical disabilities which necessitate the patient's learning how to avoid pressure sores. The conservative healing of pressure ulcers is largely dependent on good nursing with meticulous attention given to details. Correct bed positioning and the importance of regular turning are taught by the nurse in cooperation with the physical therapist and occupational therapist. The development of bowel and bladder control is one of the major goals in the rehabilitation of spinal cord injury cases, and it is certainly necessary for acceptability in "polite society." The nurse attends to the details of instruction and motivation of the patient with spinal cord injury to develop satisfactory bowel and bladder control. Only after satisfactory solution of such problems as these can work evaluation, training, and employment be expected.

c. **Surgical Services** — Major surgery is not usually provided in the usual free-standing comprehensive rehabilitation center, but is performed in an adjacent cooperating general hospital or medical center. The individual is returned to the rehabilitation center as quickly as feasible to continue other rehabilitation services during convalescense. Normally only minor surgery is anticipated in the comprehensive rehabilitation center. When conditions warrant it, however, complete surgical services may be provided. This would call for all the professional staff, operating and post-surgical care facilities, and other equipment necessary for major surgery. Surgery in a comprehensive center is of two general types:

(1) Corrective and reconstructive services — To improve functioning capacity and allow more complete, adequate physical restoration and eventual employment

(2) For intercurrent surgical conditions such as an acute appendicitis, gall gladder difficulties, etc.

d. **Paramedical**

(1) Physical Therapy — The physical therapist assists the disabled person in developing strength, usefulness, and control of the musculoskeletal system through exercise. He helps with the development of functional patterns of movement. Various modalities are used to encourage normal function by relieving pain and soreness and improving circulation. Persons with spinal cord injury are taught to stand and walk with the aid of crutches and leg braces. Lower extremity amputees are fitted with prostheses and taught to ambulate. Persons with a variety of disabilities which affect ambulation are taught how to walk and how to use any equipment which would improve walking. When physical problems cannot be entirely corrected in the center and an ongoing program of exercises and home care is needed, an appropriate home program is prescribed. Such a program may include maintaining a range of motion, avoiding the development of deformities, and eliminating complications such as pressure sores. The therapist teaches the person with prosthetic devices how to avoid complications in the use of a prosthesis or brace. Being able to sit for the number of hours required for competive employment is extremely important to an individual confined to a wheelchair. The physical therapist may teach him precautions and activity limitations which are necessary to sit safely for prolonged periods of time.

(2) Occupational Therapy — The major responsibility of the occupational therapist in a rehabilitation center is the development of self-care and competency in the activities of daily living. The occupational therapist may teach an individual how to transfer himself from his wheelchair to and from a commode, bathtub, bed, and automobile. He

may even teach the patient how to operate the hand controls of an automobile. Upper extremity amputees and persons confined to wheelchairs who expect to leave the center as homemakers are taught methods of performing typical homemaking tasks. Functional splint training for hand and arm is important for quadriplegics to develop vocational skills. The assessment of work capabilities and the growth in work tolerance are among the goals of the occupational therapist.

(3) Speech Pathology and Audiology — Speech pathology ranges from evaluating persons with various types of language and speech problems to remedial instruction for those with communication problems such as stammering, dysphasia, abnormal articulation, laryngectomy, cleft palate, cerebral palsy and other neurological conditions, and voice disorders. It also includes working with numerous speech difficulties of the aphasia victim. The exact type of any hearing deficit is determined in audiology. If needed, a hearing aid is prescribed and fitted. The client is taught the capabilities and limitations of the hearing device and is trained in its use. These services may be in cooperation with a university speech pathology and audiology center.

(4) Prosthetic and Orthotic Devices — Braces are fitted for any condition requiring their use, such as polio, paraplegia, back impairments, etc. Functional upper extremity splints are fitted, including both muscle-powered and externally-powered hand splints.

(a) Artificial limbs — Both upper and lower extremity prostheses are fitted after proper conditioning of the amputation stump. Training in effective use of these limbs is carried out in physical therapy and occupational therapy.

(b) Hearing aid — The appropriate type of equipment is determined and prescribed by the audiology department. The client is trained in the most effective use of this equipment.

(c) Electronic communication — The appropriate device along with training in its use is provided when speech cannot be acquired after a laryngectomy.

(d) Cosmetic Devices — Proper cosmetic replacements are prescribed and fitted after facial or any other body disfigurement as a result of radical surgery or loss by accident. For example, an ear or portion of a jaw might have been removed due to surgery for cancer and could be replaced with a cosmetic prosthesis. Of course, the individual is taught how to care for the prosthesis. Instruction is also given in care of the underlying skin to avoid irritations and infections.

(5) Clinical Laboratory Services — Provisions should be made for all types of laboratory work needed for the maintenance care of persons being served in the center: spinal cord injury cases, cardiac and pulmonary cases, the diabetic, etc. In exceptional circumstances research activities which require preparation and diagnosis of pathological tissues may be conducted.

(6) X-ray Services — Diagnostic equipment generally used for the type of persons served in the facility should be provided. This does not include equipment for x-ray therapy.

5. **Educational Services**

a. **General Education** — A special curriculum covering the areas in which the client is deficient is needed. Of course, education in these areas will influence the success of the client's vocational training program. The educational program provides the background material with specific types of instruction necessary in the client's field of training. This may include English, higher mathematics, or any other subject which is necessary and in which he is deficient.

b. **Special Education for the Blind and Deaf** — Special education is largely centered around communication skills. For the blind these include the following:

(1) Reading Braille, both text and written, and writing Braille
(2) Reading by listening
(3) The use of the tape recorder, transcriber, various optical aids, abacus, circular slide rule, cube writer, and arithmetic slate
(4) Remedial instruction
(5) The use of clear print
(6) Typing
(7) Mental arithmetic computation
(8) Instruction in oral communication, voice modulation, tonality, and gesticulation (for the deaf)

6. **Accommodations**

a. **Rehabilitation Nursing** — Nursing care is provided in this nursing accommodation area to the degree that it is needed by each client. The nursing care given is definitely "rehabilitation nursing" rather than the type of nursing usually provided in the general hospital. If major operative procedures are carried out in the center, and if post surgery or post operative cases are transferred early from an acute hospital, general nursing also will be required. Nursing care varies from that required for an individual who is totally dependent and unable to carry out any activities, to the minimum assistance required by those almost ready to move to the residential accommodations. These nursing accommodations are designed for those unable to carry out daily living activities and self-care which permit independent living. It is anticipated that after a period of physical restoration services, most of these cases will develop competency in self-care and daily activities and will be transferred to the residential accommodations. However, there are a few persons who can never become independent and who will remain in this area throughout the rehabilitation process. The help needed may be in dressing and transferring to and from a wheelchair, or in other essential personal activities. There must also be an adequate number of beds available for care of intercurrent illnesses occurring among the people who live in the residential accommodations. Even in the nursing accommodations it is highly desirable that all persons who are not confined to a bed during the day dress in street clothes and arise at an appropriate hour. This is very important in developing personal and group morale.

b. Residential or dormitory accommodations — These accommodations are designed for all those who are able to take care of personal needs such as dressing and toileting. Among the persons living in residential housing will be a few who will require nursing or other continued medical services which can be provided through the student health outpatient service. Such continuing services may include regular medications, wound dressings, etc. Patients should be transferred to the residential living area as early as feasible for the orderly progress of rehabilitation and development of personal independence.

7. Vocational Training

The vocational program of a comprehensive rehabilitation facility must be geared to the functional levels of the disabled whom it serves. Prerequisite education must be flexible. Many severely disabled persons have been unable to secure the usual formal education, such as completion of high school, and yet are quite capable of taking advance training in business or in other fields.

Cooperative flexible time schedules between therapy and vocational training are necessary in order to permit concurrent therapy and vocational training. The individual may be unable to take the entire training load because of time required for therapy. There may also be interruptions for surgery. Because of these interruptions and modifications, the training period usually takes considerably longer for the severely handicapped than it does for the less severely handicapped.

Adaptive equipment, modification of clothing, and architectural modifications should be used only if they are absolutely necessary. This decreases the client's sense of feeling "different" and also improves his possibilities of employment.

The range of vocational training should be as wide as is practical and should include means of adapting to multiple levels of skills and abilities. It should include training in fields open to the severely handicapped, especially to persons confined to wheelchairs. Training may include instruction in commerce, business, electronics, watch repair, drafting, commercial art, etc. It should also include courses in fields not requiring as much formal education or intelligence, such as sewing, upholstering, and repairing small appliances. Training should be provided for persons with less severe physical impairment and for those whose disabilities are not physical. There should be vocational training suitable for all types of cases served in the facility.

Training on professional and advanced technical levels should be provided by an institution of higher learning rather than by the rehabilitation center. If the center is part of an educational institution or located near one, training could proceed while therapy is still in progress at the center. There may be some people whose evaluations indicate a need for training which is not available locally. In these cases the persons should enter training in some field such as typing or drafting. This training might be useful to them later, even if they obtain further training in another field. An individual is more likely to be successfully rehabilitated if some type of vocational training is begun while physical restoration is still in progress.

8. Recreational Services

Recreation is one of the most important means of helping disabled individuals adjust to their disability and to the people around them.

Normal competition and rivalry add to a realization of personal worth and appreciation of others. Group activities and interaction teach the value of cooperation and teamwork. Recreation not only provides the stimulus to excel, but also is a means of good physical exercise. Crafts offer mental rest and relaxation while developing constructive and satisfying hobbies which may be very meaningful to the individual in the future.

9. Follow-up Services

There should be a well organized, efficiently operated follow-up department. The follow-up should extend over a prolonged period. Accurate ongoing records, including information from both the client and the employer, should be kept. The follow-up visit should be made at regular intervals; for instance, at the end of a month, six months, and then every year for the next five years. This would be of utmost value in strengthening employer-employee relations and serve to "head off" many failures.

Follow-up visits and records should also be a tool in evaluating the strong and weak points of the center's program. The records would be an accurate source of documented information on how well persons with various disabilities have adapted to the center's program. They would also indicate reasonable employment expectations of persons with specific disabilities. The records should furnish incontestable proof of the value of comprehensive rehabilitation to the individual, the community, and the general economy. The best central coordinating source for follow-up visits would probably be the record room personnel. They could develop a system to indicate the time for follow-up visits and reports and send a reminder to the person who is in charge of reporting.

Follow-up services could be conducted through a special follow-up department, the social workers or visiting nurses, or much more realistically through the client's vocation rehabilitation field counselor. The advantage of using the field counselor is that he knows the client's background, problems and training. He is in a position to make a better evaluation of the success or failure of employment and also to help solve employer-employee problems which may arise.

C. PROFESSIONAL PERSONNEL

1. Administrative Personnel

An administrator and assistant administrator will be needed. Generally neither of them is a physician. Executive ability is of prime importance in administering the complex organization, operation, finances, and public relations of such a center. Of equal importance is an intense interest in comprehensive rehabilitation, a knowledge of the field of vocational rehabilitation, and an appreciation of the relationship between medical and non-medical aspects of the program. It is desirable for the assistant administrator to be responsible for the non-medical operation of the medical department. He should be responsible for the employment of personnel, securing equipment and supplies, and the overall business operation of the medical department. Employment of professional personnel should always be in cooperation with the medical director and appropriate members of the medical staff.

2. **Medical Personnel**

   a. **Medical Director and Assistant Director** — The medical director and his assistant may be full-time[1] or part-time,[2] depending on the needs and the size of the facility. Even if the director works in the center full-time, he should maintain staff relations with cooperating hospitals. It is further desirable that he preserve his professional relations with the medical community. Either or both of the directors can be general practitioners or specialists, but should have an intense interest in and knowledge of vocational rehabilitation. They should appreciate the value of both the non-medical and medical aspects of the program. Either the medical director or his assistant should have special competency in physical and occupational therapy and be in charge of the therapy department. This usually means that either the director or the assistant director must be a physiatrist or an orthopedic surgeon. Either the medical director or the assistant medical director should perform diagnostic work.

   b. **Other Medical Personnel**

      (1) Student Health Physician — This person should preferably be a general practitioner or internist. He may be employed either full-time or part-time. It is his duty to conduct "sick call" and to treat intercurrent illnesses.

      (2) Internist — The internist may work part-time or as a consultant,[3] depending on whether or not the director or the student health physician is an internist.

      (3) Orthopedic Surgeon — The orthopedic surgeon may be full-time or part-time, depending on whether he is in charge of the therapy department.

      (4) Physiatrist — Full-time

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[1] "Full-time" — It is desirable that even if "full-time", he maintain staff relations with cooperating hospital or hospitals. He should participate in the medical community.

[2] "Part-time" is considered to be a physician who makes regular, periodic visits to the center and has regular specified duties.

[3] "Consultant" is a physician who is called on when needed, either for services in his own office or at the center.

(5) Urologist — Part-time
(6) General Surgeon — Consultant
(7) Psychiatrist — Part-time
(8) Opthalmologist — Part-time
(9) Otolaryngologist — Consultant
(10) Radiologist — Part-time
(11) Dentist — The dentist may be part-time or full-time, depending on the scope of the dental program and the size of the center.

3. **Paramedical Personnel**

a. **Nurses** — The nursing staff should have special competency in rehabilitation nursing.

b. **Physicial Therapist** — The physical therapist should be trained in rehabilitation of the severely disabled such as amputees, persons with spinal cord injuries, or hemiplegics. One or more physical therapists should be trained in the mobility of the blind if blind persons are served in this center. The number of physical therapists needed will depend upon the case load.

c. **Occupational Therapist** — The occupational therapist should be trained in functional occupational therapy. Probably more than one will be needed. They should be competent in teaching the severely disabled activities of daily living, self-care, and vocational skills.

d. **Speech Pathologist and Audiologist** — The speech pathologist should be competent in teaching esophageal speech, training the aphasic, helping the stammerer, etc. The audiologist should be competent in audiological evaluation, fitting hearing aids, and training patients as to how to use hearing aids.

e. **Clinical Laboratory Technician** — The clinical laboratory technician should be skilled in performing all tests necessary in the medical maintenance of the patients. It may be necessary to have more than one person in this area.

f. **X-ray Technician** — The X-ray staff should be knowledgeable in all diagnostic x-ray procedures.

g. **Pharmacist** — The pharmacist should be responsible for procuring and dispersing all needed medicines. He may be either full-time or part-time.

h. **Medical Records Librarian** — This staff member should be trained in approved methods of keeping records, coding diagnoses, etc. This is necessary in the event that records are requested by sources outside the center.

4. **Vocational Evaluation Personnel**

a. **Supervisor** — The evaluation supervisor is usually a rehabilitation counselor. He has overall supervision, direction, and coordination of the evaluation program and serves as liaison between the referring agency and the evaluation unit. The supervisor is responsible for seeing that all necessary information, records, x-rays, etc., are available when the client is presented for evaluation. He formulates a vocational recommendation based on the information developed by various members of the evaluation group. The supervisor is responsible for sending the report and recommendations to appropriate persons. Any questions from referring sources regarding reports and recommendations are cleared through him.

b. **Rehabilitation Counselor(s)** — The vocational rehabilitation counselor should be trained in assessing the vocational needs of the client. He should utilize every person on the evaluation team to determine the client's liabilities and assets and to aid the client in determining a vocational goal. The counselor should guide the client through training, placement, and follow-up.

c. **Clinical Psychologist** — This staff person should be skilled in the administration of various tests. He should also be able to interpret these tests in light of the work evaluation and the client's needs for vocational training and employment. He should be thoroughly oriented in comprehensive rehabilitation.

d. **Physician** — Part-time

e. **Work Evaluator** — This person should be trained in special techniques of evaluation for dexterity, interests, mechanical ability, work tryouts, work sampling, work tolerance, etc. It is possible that more than one work evaluator will be needed.

f. **Recreational Therapist** — The recreational therapist should be trained in personality adjustment, interaction, and group dynamics. His function is to aid the disabled individual in adjusting to his impairment and to people with whom he must relate personally. Of course, the recreational therapist should have a basic knowledge of games, crafts, and entertainment.

g. **Social Worker(s)** — The social worker is concerned with the client's social, family, and economic problems. Through casework counseling he attempts to help the disabled person adjust to these problems.

5. **Educational Personnel**

There should be an adequate number and variety of teachers to offer clients a general background of information needed in every day life and in employment. Courses might include English, mathematics, etc. Special teachers will be needed for the deaf and the blind if the center serves such persons. These teachers will teach communication skills such as reading and writing Braille, esophageal speech, etc., to the deaf and blind.

6. **Chaplain**

This staff member should have sound training in Biblical interpretation of disability. He should have clinical pastoral counseling which would equip him for supportive counseling relative to the client's religious, social, physical, and vocational problems.

7. **Vocational Training Personnel**

There should be a director of vocational training to supervise the teaching staff, develop client-centered curricula, and see that each client's training needs are met. An assistant vocational director might help him with these responsibilities. The teachers would of necessity be varied so as to offer all types of vocational training, and all of them should be oriented in comprehensive rehabilitation.

D. SPECIAL EQUIPMENT

1. **Availability of Equipment**

In general, all equipment necessary for the rehabilitation of those served in the center should be available.

2. **Degree to which unusual equipment is needed**

Complete diagnosis of complex pathological conditions requiring extensive laboratory work and special examinations will seldom be conducted in this facility. Cases of severe acute illness will not generally be treated in the medical unit, but rather will be transferred to an allied hospital. All equipment necessary for medical maintenance during therapy and training should be provided. Except in special circumstances, major surgery will be performed in an allied hospital rather than in the center. Therefore, major operative surgery is unnecessary.

3. **Equipment needed**

The following list of equipment is needed. This list is subject to change, depending on existing conditions.

a. **Clinical Laboratory Equipment** — The clinical laboratory equipment should be adequate to perform all tests needed for the maintenance care of patients. This would include serology, bacteriology, hematology, blood chemistry, etc. Pathological tissue examination is not anticipated.

b. **X-ray Equipment** — The X-ray equipment should include that necessary for diagnostic purposes. Automated equipment in a darkroom is desirable for rapid processing of film. No X-ray therapy is anticipated.

c. **Physical Therapy Equipment**

(1) Parallel Bars — Some 30' - 40' long bars, and some short standing bars

(2) Treatment tables — 30" high and 30" wide, vinyl covered

(3) Muscle-strengthening equipment — Wall weight type

(4) Treatment tables — Wheelchair height, 60" or 72" wide, vinyl covered

(5) Floor mats — Vinyl covered

(6) Resistance exercise table

(7) Tilt tables

(8) Mirrors — Wall and mobile types

(9) Steps and ramps

(10) Cervical and pelvic traction equipment

(11) Lifting weights arranged for supine use

(12) Shoulder wheel

(13) Hydroculator — Hot and cold

(14) Paraffin bath

(15) Hubbard tub with nylon webbing stretcher

(16) Whirlpool bath

(17) Moist hot air cabinet

(18) Equipment for infrared, shortwave, and Dynawave treatment

(19) Equipment for ultrasound, electrical nerve testing, and stimulation

(20) Hydraulic lift

(21) Electromiographic unit — Mobile

d. **Occupational Therapy Equipment**

(1) Work tables — One work table with hydraulic height adjustment

(2) Typewriters — Manual and electric

(3) Loom

(4) Workbench

(5) Hand tools for woodworking, plumbing, metal work, and painting

(6) Standing tables

(7) Manual dexterity games and equipment such as checkers and building blocks

(8) ADL (activities of daily living) test board

(9) Treatment table — Wheelchair height, 60" wide

(10) Floor mat — Vinyl covered
(11) Hydraulic lift
(12) Sand or gravel pit
(13) Lawn mower
(14) Rake, hoe, pick, shovel
(15) Wheelbarrow
(16) Hedge clippers
(17) Stepladder
(18) Sliding boards
(19) A two-door automobile — Should be available regularly for transfer training
(20) Training bathroom with standard fixtures arranged to accommodate a wheelchair person
    (a) Hand bars transfer
    (b) Basin — Height for wheelchair
    (c) Bathtub — Standard with hand bars and with a curtain rather than an enclosure
    (d) Shower built to allow use of a shower wheelchair or rolling wheelchair
    (e) Shower wheelchair or rolling stool
    (f) Commode seat — Elevated, removable
    (g) Commode placed so as to permit front or side transfers
(21) Training bedroom — Bed with round overhead bar
(22) Training kitchen — Usual furnishings with only necessary modifications and adaptive equipment
    (a) Cabinets — 30" high to accommodate wheelchair individuals
    (b) Stove — Oven beneath or at counter level; 30" high, controls on front or side rather than at the back; placed so as to allow a wheelchair to approach from the side
    (c) Sink — Open beneath or with swing-away doors to permit approach with wheelchair; minimum depth, 30" high
    (d) Washing machine
    (e) Clothes dryer
    (f) Ironing board

e. **Prosthetic and Orthotic Equipment** — There should be a small shop for modifying and fitting artificial limbs and braces. It should have a work bench, vise, drill press, band saw, and other necessary hand tools. This shop is also for use of the occupational therapist and physical therapist. A shop for the fabrication of limbs and braces should be included if needed.

If such a shop is desirable, it could be located almost anywhere in the center.

f. Speech and Hearing Equipment

(1) Tape recorder — Two channel, high fidelity
(2) Auditory training unit
(3) Language master and related stimulus materials
(4) Amplifier unit including microphone and earphones, spirometers, and examination equipment
(5) Magnetic tapes and other speech pathology test materials
(6) Diagnostic clinical audiometer with accessory units
(7) Bekesy — Type audiometer
(8) Psycho — Galvanometric skin reflex testing unit
(9) Phonograph
(10) Variable electronic filters
(11) Speaker switching console
(12) Blackboard
(13) Observation mirror

g. Cardio-pulmonary Equipment

(1) Pulmonary functioning
    (a) One-second forced expiration volume equipment
    (b) Peak forced expiration flow equipment
    (c) Maximum mid-expiratory flow equipment
    (d) Single-breath nitrogen wash-out test materials
(2) Cardiology
    (a) Electrocardiograph
    (b) Exercise equipment — Bicycle or treadmill type

h. Work Evaluation Equipment — All equipment needed for administering pre-vocational tests, determining manual dexterity, and work sampling should be provided.

i. Vocational Training Equipment — The equipment needed will be determined by the fields of training offered. The vocational training program should be broad enough to meet the needs of a diversified group of clients in respect to age, formal education, physical conditions, mobility, mentality, interest, and aptitudes. Equipment should be adequate to permit training for acceptable competitive employment. Where possible, equipment which is adjustable in height should be secured.

j. Recreational Equipment — There should be provisions for both indoor and outdoor recreation.

(1) Swimming pool
(2) Billiards equipment

(3) Ping pong equipment
(4) Weight lifting room
(5) Multi-purpose gymnasium
(6) Bowling alleys
(7) Rifle and archery range (The same room may be used for both.)
(8) TV viewing room
(9) Stereophonic record equipment
(10) Library and reading room
(11) Music room
(12) Auditorium with 35mm projection equipment
(13) Stage equipped for theatrical productions
(14) All equipment and materials necessary for crafts such as ceramics, leather work, lapidary, jewelry making, archery equipment construction, fly tying, weaving, rug hooking, needlepoint, knitting, metal work, enameling, etc.

k. **Equipment for Clinical Instruction As Well As Therapy** — Closed circuit TV and sound tape for use in gait training and clinical instruction, case records, and lectures.

E. SUMMARY

The free-standing comprehensive rehabilitation center is very helpful in meeting the needs of disabled persons, and particularly those severely disabled. This type of center offers a comprehensive range of services or else cooperates with other facilities which provide services not offered in the center itself. A comprehensive center has the unique advantage of bringing together in close proximity all services needed by the disabled, enabling them to proceed with work evaluation, training, etc., while physical restoration is still going on. Such a center must have a wide variety of professional staff and appropriate equipment.

CHAPTER II

A REHABILITATION UNIT IN A GENERAL OR SPECIAL HOSPITAL

A. INTRODUCTION

A complete rehabilitation unit in a general or special hospital can meet the total rehabilitation needs of most persons with physical, mental, and emotional disabilities. If a comprehensive unit exists in a hospital reasonably near the disabled person's home, he can be rehabilitated with minimal disruption of family and community relations. Ideally such a facility should provide all the services needed to return the disabled individual to his place in society as a self-respecting, participating, productive citizen.[1] However, it may not be possible or practical for a hospital to provide all of these services from the beginning. Most hospitals will probably have to adopt only a part of this program at first and gradually add other services until a comprehensive program has been developed.

A hospital-based rehabilitation unit is not expected to render every service needed by the disabled persons it serves. In order to be truly comprehensive, working arrangements must be established to provide these other services elsewhere in the community. The services outside the hospital which will probably be required are vocational training and suitable residential housing. These services will be for patients who do not have to be in the hospital for inpatient care. All available vocational training facilities in the community should be utilized to the maximum degree. A training facility can be developed to provide some types of special training if not available in the community. By following this plan, the hospital-based facility may become as truly complete as comprehensive as the free standing rehabilitation center described in Chapter I and will avoid the necessity of establishing such a center. There are certain advantages in this approach in that there can be a process of growth and gradual development which simplifies the problems of financing while strengthening cooperative relations with local training facilities and promoting public interest. The completeness of the program is determined by the size and character of the caseload and the completeness of training offered through community training facilities which would not be available in the hospital-based rehabilitation unit. Residential housing can be provided by a dormitory type building without architectural barriers and having provision for food service. This housing should be accessible to the physical restoration, evaluation and counseling services located in the hospital. Any special vocational training facility found to be necessary could best be located in conjunction with the residential unit.

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[1] The comprehensive unit does not necessarily serve persons with every disability, but it does provide all the services needed by persons with the disabilities which it is designed to serve.

B. ORGANIZATION

The rehabilitation unit should be a distinct rehabilitation service in the sense of having a complete rehabilitation staff, at least one ward with rehabilitation nursing, and a rehabilitation outpatient service. The medical director should be in charge of both the inpatient and outpatient services. Vocationally oriented physical therapy, occupational therapy, and speech pathology and audiology services should be available. There should be close cooperation between the hospital staff, its administration, and the Vocational Rehabilitation personnel. The size of the rehabilitation unit depends on local conditions such as the size of the hospital, the local metropolitan and area population, and the availability of affiliated vocational training and other services.

1. Rehabilitation Wards

Rehabilitation wards should be designated for only rehabilitation cases. In these wards emphasis should be placed on personal independence and the patient caring for his own needs rather than being served by others. All persons not confined to bed should wear street clothing, and all who are able to do so should eat in a public dining area. This promotes a more normal and less hospital-like atmosphere. The rehabilitation ward or wards should be easily accessible to the therapy departments and the evaluation unit.

2. Residential Accommodations

This type of housing is absolutely necessary for orderly progression toward independent living in society. All patients capable of caring for themselves and carrying on the activities of daily living should be housed in this area if there is no other reason why they must stay in the hospital. They should not require nursing care except through the rehabilitation outpatient service. Therefore only supervisory personnel and maid and janitorial services are anticipated for these accommodations.

Residential accommodations can be a part of a hospital building or can be located in a separate building owned by the hospital. These facilities could possibly be owned and operated privately by some group or organization, but they must be available. The housing area may provide the desired setting of a "halfway house" for the rehabilitation of psychiatric cases. Dining arrangements must be made. The residential accommodations must be constructed without architectural barriers for persons in wheelchairs or those with other types of handicaps. There must be satisfactory transportation to and from the hospital for therapy and other services if no direct architectural connection between the two buildings exists.

D. SERVICES OFFERED

1. Medical Services

a. **Physicians** — The physicians on the staff should provide physical restoration services and should also be available as consultants.

b. **Nurses** — Nursing services should emphasize rehabilitation-oriented nursing in the rehabilitation wards and the outpatient service.

2. Paramedical Services

a. **Physical Therapy** — Physical therapy should be oriented toward vocational rehabilitation as well as the usual type of hospital physical therapy.

b. **Occupational Therapy** -- Occupational therapy should be functionally oriented. Severely disabled persons such as amputees, those with spinal cord injuries, and hemiplegics should be instructed in how to care for themselves and carry on the activities of daily living.

c. **Speech Pathology and Audiology** — Speech pathology and audiology should offer complete speech and hearing evaluations, treatment, instruction in the use of hearing aids, and other services in order to provide for the needs of persons with communication problems.

d. **Cardio-pulmonary Services** -- These should include comprehensive cardiac and pulmonary evaluation and treatment through a heart station and a complete pulmonary function laboratory.

e. **Social services and/or visiting nurses** — Social workers or visiting nurses should be responsible for social, family, and economic background records, case work counseling, and follow-up home visits after the patient leaves the hospital.

f. **Prosthetic and orthotic services** -- These services should include fitting of prosthetic and orthotic devices and training in how to use them.

g. **Clinical laboratory services** — Laboratory services should include all diagnostic, treatment, medical maintenance, and research laboratory procedures necessary to serve severely disabled individuals.

h. **X-ray services** — Provisions should be made for diagnostic evaluation and treatment of the various disabilities of persons served in the rehabilitation unit.

3. Rehabilitation Services

The majority, and perhaps all, of the psycho-social, medical, and vocational evaluation services should be located near the rehabilitation wards and outpatient service. This would be especially helpful to cases transferred to the hospital following some crippling injury, disease, or surgery. The possibilities of social adjustment and future employment can be determined more realistically. Rehabilitation services should minimize the emotional and psychological problems, such as discouragement, which often follow severe physical trauma. The rehabilitation process should start while the patient is still confined to bed. The complete evaluation of other cases admitted for evaluation and physical restoration, and of outpatient clients, can be conducted wherever the professional personnel and departments of the hospital can most easily be located.

4. Evaluation Services

The evaluation services in the outpatient part of the rehabilitation unit should be available both for inpatients and outpatients. The evaluation should be broad in scope and quite comprehensive in character. Evaluation should be for persons of all levels of mental capacity and formal education. Evaluation services should be designed for fields of training which are not already accessible to the client. Of course, physical disabilities and limitations must be taken into consideration.

a. **Psycho-Social Evaluation** — The client's family, community, and economic background should be examined in light of any present social or psychological maladjustment. This investigation may be carried out by the social worker in the hospital unit or by a field social worker, or both may enter into this phase of evaluation. The field rehabilitation counselor may also be helpful. This information might also be secured by visiting nurses or other appropriate personnel, depending on their availability. A meaningful psycho-social history should be obtained before the client is presented for evaluation. When individuals have already been admitted to the hospital or have been referred for rehabilitation services, background information should be secured immediately. Psychological examinations should be conducted by a clinical psychologist. An appropriate battery of tests should be administered to determine the mental ability of the individual as well as his aptitudes and interests. The interpretation of these test results requires a clear knowledge of the rehabilitation problems involved.

b. **Medical Evaluation** — A general medical examination will be sufficient in some cases, while an examination by one or more specialists will be needed in other cases. The purpose of the medical examination is to determine the client's physical capacities and his limitations. It is very important to know exactly what activities an individual can safely participate in, and to what degree he can participate.

c. **Work Evaluation** — The work evaluator's function is to extensively explore a wide field of vocational possibilities ranging from unskilled and illiterate levels to the commercial, technical, and professional levels. This service should be located in the hospital plant in order to allow individuals confined to the hospital to be evaluated and to begin developing vocational plans. However, more complete work sampling and tryouts may be obtained through the vocational training facility or work-oriented facility than are possible in the hospital.

5. Vocational Counseling Services

Vocational rehabilitation counselors provide assistance to clients in formulating vocational goals, obtaining training, finding employment, work adjustment, and follow-up. One or more vocational counselors should be assigned full-time to the hospital service, and they should work in cooperation with the field counselors. The supervisor of counselors should have overall supervision of the vocational rehabilitation program in the hospital and of allied training. He is the key contact person between the Division of Vocational Rehabilitation and the medical profession and hospital administration.

6. Vocational Training Services

A hospital cannot realistically be expected to provide the vocational training necessary for a comprehensive rehabilitation unit. If the hospital maintains a training program in these areas, training may be offered in the hospital in either professional or practical nursing, physical therapy, occupational therapy, laboratory technology, and X-ray technology. Training may be offered for nurses' aides, orderlies, food service personnel, and in similar skills. Only a relatively small number of clients can receive their training in the hospital and utilize areas of employment in the hospital for tryouts in work evaluation.

Allied cooperating training facilities must provide the bulk of vocational training. These facilities may include pre-existing vocational and training facilities designed to serve the needs of a single disability group, or various disability groups, with vocational training and/or extended sheltered employment. In order to provide appropriate vocational training for the variety of disabled persons to be served, in most cases it will be necessary to rely on a vocational training facility or work-oriented facility to furnish the additional training services needed.

a. **Vocational Training Facility** — This training facility should be located near or adjoining the residential unit and should be easily accessible to the hospital. Whether it is sponsored by the community or some other group, the training curriculum should be planned and organized to meet the client's training needs which are not met in other ways. The nature and extent of the training offered in such a facility will vary widely in different localities, depending on the training needs of those served and the availability of other suitable training facilities. Such a facility might provide only vocational training for competitive employment, or it might have limited provisions for extended sheltered employment.

b. **Professional, Technical and Business Training** — When the hospital is part of an educational complex or institution of higher learning, training in a suitable professional, technical, or business field may be feasible. Physical restoration services and training services may be conducted concurrently.

c. **Technical, Business, and Trade Training** — This training may be provided through local vocational or technical schools while therapy and adjustment are still in progress.

7. Outpatient Services

This phase of the program is designed to meet the needs of those in the residential unit and of other outpatients who need therapy, evaluation, or counseling. Its services are for persons requiring supervised medication, dressings for wounds or ulcers, physical therapy, occupational therapy, speech therapy, assistance in developing satisfactory bowel and bladder control, etc. "Sick call" services to care for the intercurrent illnesses of those in the residential unit should be handled in the outpatient area, but this outpatient service should be separated from other outpatient services of the hospital, at least in scheduling if not in the physical plant. This is desirable in order to maintain rehabilitation cases as a group and to avoid the confusion of having them interspersed with other types of cases.

8. Recreational Services

Recreation is an important part of the total rehabilitation process. It promotes personal and social adjustment, develops a cooperative attitude, generates an appreciation for the value of cooperation, and provides helpful physical exercise. Provisions should be made for both indoor and outdoor recreation. Indoor recreation should include crafts which provide mental rest and relaxation as well as lead to rewarding hobbies.

9. Follow-up Services

There should be an efficient, workable, follow-up service. Follow-up should extend over a prolonged period with accurate ongoing records. This service can probably be maintained best through the record room, with information secured and reported by the client's rehabilitation counselor. A realistic period of follow-up would be five years with a report at the end of the first six months, and then annually. A system could be set up so that when a person's record goes to the record room upon his discharge, his name would be noted on a follow-up calendar. The counselor would be notified, and reminded if necessary, when a follow-up visit and report are due. These periodic reports would furnish information about the employer as well as the client. Such long-term follow-up would provide invaluable information regarding the effectiveness of the hospital's rehabilitation unit. The follow-up program would indicate the strength and the weaknesses of the rehabilitation program, providing opportunity for upgrading the unit's services.

E. PROFESSIONAL PERSONNEL

1. Medical Director

The medical director may be a general practitioner or a specialist, provided he meets the qualifications of a medical director. If the size of the unit justifies it, there should be an assistant medical director whose qualifications are identical to those of the medical director. Since the director or the assistant director must be competent in prescribing and supervising the therapy program, one of them will usually be an orthopedic surgeon or physiatrist. The director should not only exhibit executive ability, but also have an intense interest in comprehensive rehabilitation and an understanding of the relationship between the medical and non-medical aspects of the rehabilitation process. He may be full-time or part-time, depending on the program desired. The director should be employed and remunerated for his services on a mutually acceptable basis. Even if he is full-time, he should remain active in community medical affairs.

The medical director is responsible for the administration and coordination of the entire inpatient and outpatient physical restoration program. He orders therapy for patients at the request of their physicians, and either he or the assistant medical director may supervise therapy. The medical director consults with physicians, therapist, and vocational rehabilitation personnel in regard to rehabilitation clients.

2. **Coordinator**

If the unit is large enough to justify it, there should be an administrator in charge of business procedures of the operation. He should coordinate the activities of all organizations, institutions, and agencies involved, and he should also have major responsibility for public relations. He should have intense interest in rehabilitation, fully appreciating the relationship between the medical and non-medical phases of the rehabilitation program. He should be involved in the employment of professional personnel for the rehabilitation unit.

3. **Rehabilitation Nurse**

This person should be fully competent in rehabilitation nursing. She should be responsible for nursing care in the rehabilitation wards and outpatient services and for training nurses and supportive personnel in proper rehabilitation nursing care. She and her staff are largely responsible for the bowel and bladder control training of persons with spinal cord injuries.

4. **Paramedical Personnel**

a. **Physical Therapist** — The physical therapist should be trained in the rehabilitation of severely disabled persons such as amputees, individuals with spinal cord injuries, and hemiplegics. Of course, he should also be skilled in working with the usual types of cases found in hospitals.

b. **Occupational Therapist** — The occupational therapist should be trained in functional occupational therapy and should be competent in handling the severely disabled. It is the responsibility of the occupational therapist to help clients develop abilities in activities of daily living, self-care, and vocational skills.

c. **Speech Pathologist and Audiologist** — The speech pathologist and audiologist should be competent in handling any speech and hearing problem referred to the rehabilitation unit.

d. **Clinical Psychologist** — The clinical psychologist must be oriented in vocational rehabilitation. He should have a realistic understanding of the relation between psychological test results, practical training, and employment.

5. **Vocational Rehabilitation Personnel**

a. **Supervisor** — The supervisor has overall responsibility for vocational aspects of the rehabilitation program. He serves as liaison person and coordinator between the Division of Vocational Rehabilitation and the medical services, hospital administration, and vocational training program in the community. The coordinator also functions closely with the director of the unit. He serves as the contact person between referring agencies of individuals and the rehabilitation unit and is responsible for procuring all necessary records and information when a client is referred or admitted. He assures prompt forwarding of information, reports, and recommendations to any appropriate person.

b. **Counselor(s)** — Full-time rehabilitation counselors should be assigned to work in the hospital. The number of counselors needed will vary according to the scope of the rehabilitation program and size of the areawide rehabilitation case load. Their function is helping clients develop vocational plans. This involves work evaluation, vocational training, and vocational counseling.

c. **Work Evaluator** — The evaluator is a person especially trained in techniques of evaluation related to dexterity, work tryouts, work sampling, etc.

6. Social Worker

A social worker, or else visiting nurses, should maintain contact with the client's family and home community. This service may be enhanced by using the home field counselor also.

7. Recreational Therapist

The recreational therapist should be skilled in helping disabled persons adjust to the disabilities, cultivate pleasant relationships with others, exercise sufficiently, and develop new interests and hobbies.

8. Chaplain

The chaplain should have a positive attitude toward Biblical interpretation of disability. He should also have training in supportive counseling, and should be able to render any general type of counseling which the clients might need.

9. Vocational Training Coordinator

The vocational training coordinator should coordinate the training programs in the various facilities being used by the hospital unit for vocational training. The personnel needed in the vocational training program will depend on the organization of the program.

F. SPECIAL EQUIPMENT

1. Areas for Which Special Equipment is Needed

Special equipment is needed for a rehabilitation unit in a general or special hospital in the physical therapy, occupational therapy, and speech pathology and audiology departments.

2. Listing of Equipment

The lists that follow probably include equipment already in specific departments. The equipment listed are essential for the departments to provide appropriate treatment for the various disabilities expected in such a unit.

a. **Equipment for Physical Therapy**

  - (1) Parallel bars — Some 30' to 40' in length, and some short standing bars
  - (2) Treatment tables — 30" high and 30" wide, vinyl covered
  - (3) Muscle-strengthening equipment — Wall type
  - (4) Treatment tables — Wheelchair height, 60" or 72" wide, vinyl covered
  - (5) Floor mats — Vinyl covered
  - (6) Tilt table
  - (7) Resistance exercise table
  - (8) Weights — Arranged for supine lifting
  - (9) Shoulder wheel
  - (10) Hydroculator — Hot and cold
  - (11) Paraffin bath
  - (12) Hubbard tub with nylon webbing stretcher
  - (13) Whirlpool bath
  - (14) Steps and ramps
  - (15) Wall mirrors as needed
  - (16) Moist hot air cabinet
  - (17) Infrared, shortwave, dynowave, ultrasound, and electrical nerve testing and stimulating equipment
  - (18) Electromiographic unit — Mobile (optional)
  - (19) Hydraulic lift

b. **Equipment for Occupational Therapy**

  - (1) **Equipment for the Training Bathroom**
    - (a) Standard fixtures arranged to accommodate a wheelchair person, with hand bars for transfers
    - (b) Basin — Wheelchair height
    - (c) Tub — Standard, with curtain rather than sliding panels, hand bars
    - (d) Shower — Built to allow use of shower wheelchair or rolling stool
    - (e) Shower wheelchair
    - (f) Rolling stool
    - (g) Removable elevated commode seat
    - (h) Commode — Placed so as to admit front or side transfers
  - (2) **Equipment for Training Bedroom**
    - (a) Bed — Standard height with round overhead bar
    - (b) Other standard furnitures
  - (3) **Equipment for Training Kitchen**
    - (a) Cabinets — 30" high to accommodate person in wheelchair

(b) Sink — 30" high, shallow (minimum standard depth), open underneath or with swing-away doors to permit a wheelchair to approach the sink
(c) Stove — 30" high, oven beneath or at counter level, controls on the front or side rather than the back, placed so as to leave one end free to allow a wheelchair to approach the side
(d) Washing machine
(e) Clothes dryer
(f) Ironing board
(g) Iron
(h) Other equipment usually in the kitchen — Standard

(4) **Miscellaneous Equipment**
(a) Work table with hydraulic height adjustment
(b) Typewriters — Manual and electric
(c) Loom
(d) Work bench
(e) Hand tools for woodworking, plumbing, metal work, and painting
(f) Standing table
(g) Manual dexterity games and equipment — Checkers, building blocks, etc.
(h) ADL (Activities of Daily Living) test board
(i) Floor mat
(j) Hydraulic lift
(k) Sand or gravel pit
(l) Lawn mower
(m) Rake, hoe, pick, and shovel
(n) Wheelbarrow
(o) Hedge clippers
(p) Stepladder
(q) Two-door automobile for transfer training — Must be available on a regular basis
(r) Sliding boards

c. Speech and Hearing Equipment — Preferably located at the end of a corridor remote from noises and vibration-producing machinery, and in windowless air-conditioned rooms. There should be one soundproof room and other sound-treated rooms.

(1) Tape recorder — Two channel, high fidelity
(2) Auditory training unit
(3) Language master and related stimulus materials
(4) Amplifier unit including microphone and ear-

phones, spirometers, and examination equipment

(5) Magnetic tapes and other speech pathology test materials
(6) Diagnostic clinical audiometer with accessory units
(7) Bekesy — Type audiometer
(8) Psycho — Galvanometric skin reflex testing unit
(9) Phonograph
(10) Variable electronic filters
(11) Speaker switching console
(12) Blackboard
(13) Observation mirror

G. SUMMARY

It is generally impossible for a hospital to add a wide range of rehabilitative services at one time. More often hospitals find it necessary to add services little by little, gradually working toward the goal of a comprehensive range of services. Even so, it is not feasible for a hospital to offer absolutely every rehabilitation service. Some services may already be available locally, and some might well be offered by a facility other than the hospital. In planning to meet rehabilitation needs, a hospital board and staff should carefully consider community resources and plan services so as to enhance rather than duplicate existing services.

For instance, training services may be available locally. If not, it may be necessary for a training facility to be developed.

CHAPTER III
GENERAL ARCHITECTURAL PRINCIPLES FOR REHABILITATION FACILITIES

A. INTRODUCTION

It would be unrealistic to recommend specific building plans for the various rehabilitation facilities. Facilities in different localities will probably vary a great deal in design and arrangement. Each facility should be suited to the geographical area and to the purpose for which it is designed. However, there are certain basic architectural principles which have general value. These general principles and specifications apply to all types of rehabilitation facilities dedicated to meet the needs of disabled clients. They relate to certain functional areas which are important in a comprehensive rehabilitation program.

B. CHARACTERISTICS OF THE PHYSICAL PLANT

1. General Characteristics

a. One or More Stories — The facility may be housed in a single multi-story building or may consist of multiple buildings of one or more stories. This will be determined according to the terrain, size of the property, or what is available. If a multi-story building is used, elevator service should be adequate. At least one elevator must be large enough to transfer a bed.

b. Construction

(1) There should be no serious architectural barriers.

(2) Entrances and exits should be such that the disabled person can enter or leave with ease. All doors should be wide enough for wheelchairs, and corridors should be at least eight feet wide to accommodate passing wheelchairs. There should be some means of efficient evacuation of the severely disabled in case of fire.

(3) Electric service outlets should be 36" to 48" above the floor.

(4) The construction should permit changes in the use of any area with a minimum of remodeling.

c. Arrangement -- There should be ease of movement between all areas. For example, a minimal length of time should be required to go from a training area to therapy or to the dining area.

d. Floors — Floors should not be slick.

e. Temperature — There should be full air-conditioning, if possible, with area temperature controls. The room temperature is very important in performing certain activities such as those involved in physical therapy.

2. **Characteristics of the medical section**

   a. **Rehabilitation Nursing Area or Hospital Rehabilitation Wards** — The "hospital" appearance should be avoided as much as possible. Room furnishings should be functional but should not look like a typical hospital. The floor arrangement should be such that general institutional traffic does not pass through the nursing care area.

      (1) Patient's Room

         (a) Beds should be fitted with round overhead bars when needed. The height of the bed should be adjustable. All beds should be of the "Gatch" type.

         (b) There should be adequate space in patients' rooms for "parking" wheelchairs.

         (c) Adequate closets and other storage space should be provided, because all patients will wear street clothing when out of bed and therefore will need more closet space. Also, some patients will remain in this section for a prolonged period and may want to keep many of their belongings with them.

      (2) Wards

         (a) There should be provisions for personal privacy in wards by using sliding curtains, accordion partitions, or preferably wall room dividers with the enclosure completed by sliding curtains. The wall room divider has the advantage of providing much extra storage space.

         (b) Adequate space for storage of wheelchairs, stretchers, spare mattresses, patients' luggage, etc., should be provided on the ward.

   b. **Medical Offices** — Clients on their way to therapy should not ordinarily pass through the office area.

      (1) There should be private offices for the chief of occupational therapy and also for the chief of physical therapy. Therapy staff offices should provide desk space for staff therapists as well as clinical affiliated students.

      (2) The physicians' offices should be adequate in size for a chair and desk, two patients' chairs, and a wheelchair; however, they should be no larger than necessary for these items. There should be no examining table in the physician's office.

   c. **Conference Room** — The conference room should be large enough for the entire therapy staff and the clinical affiliated students. It should be located near the offices. This room may possibly be divided by folding partitions in order to form two or more smaller rooms when desired.

3. **Paramedical Section**

   a. **Physical Therapy**

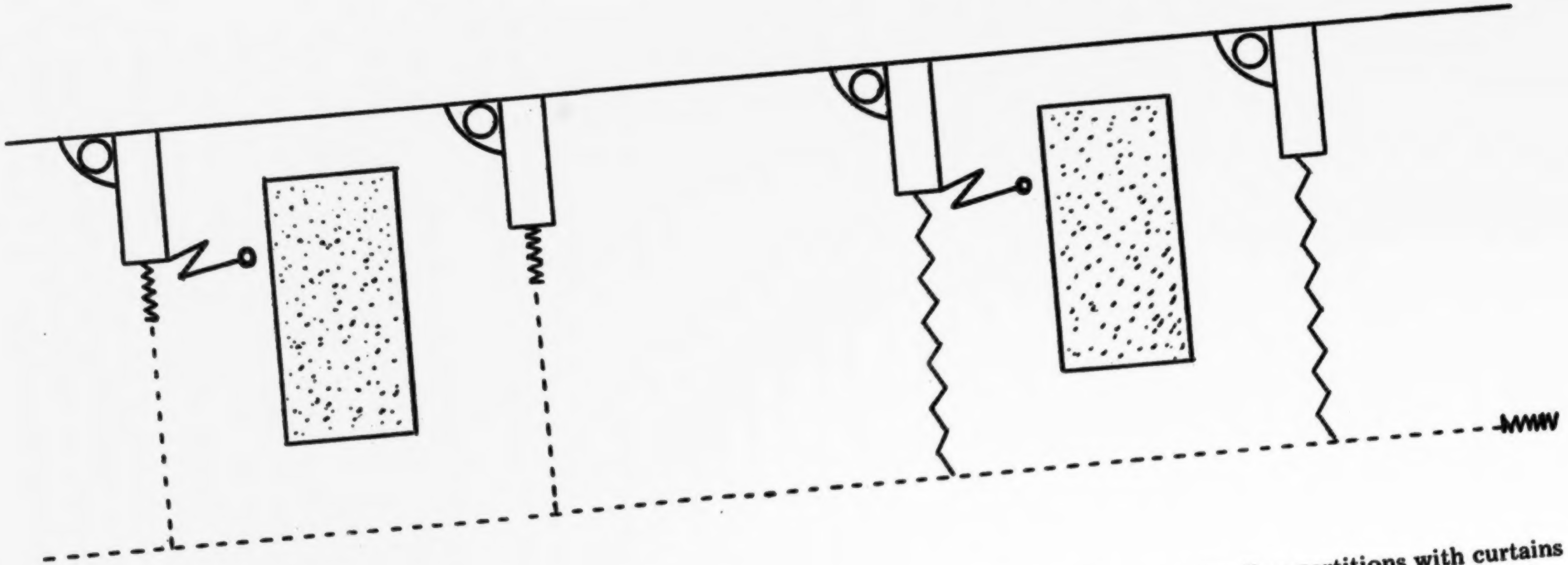
      (1) The physical therapy department should be located adjacent to the occupational therapy department. In fact, the use of different parts of a large open room for both purposes would have many advantages, if the building construction permits this.

      (2) This department should be as open as possible without unnecessary permanent partitions or divisions into separate rooms. Hydrotherapy may be in a separate room, especially if a therapeutic pool is used. If a pool is not used, sliding curtains or folding partitions are adequate. Storage space should be sufficient and easily accessible. General lighting should be indirect, and there should be a spotlight for treatment tables. The ceiling should be acoustic.

      (3) Treatment booths should be enclosed, possibly by sliding curtains, but preferably by accordion partitions and with the entrance covered by a curtain. The arrangement is simplified and more efficient if a partial built-in divider is located between each booth. This should be curtain height and should extend into the room 24 to 36 inches from the wall with storage shelves on one side. Each cubicle should have a lavatory, mirror, and arrangements for handling patients' clothing. If a built-in divider is used, then it can be used for this equipment, thus eliminating the need for an equipment table. A spotlight should swing from the divider (see diagram on following page).

      (4) Plumbing should be arranged for rapid filling and draining of the whirlpool baths and Hubbard tub, and this calls for a 4" pipe. Whirlpool baths should be mobile.

   b. **Occupational Therapy** -- This department should be designed for functional occupational therapists to help clients develop self-care, activities of daily living, useful skills, and work tolerance. It should be as open in construction as possible with minimum division into separate rooms. This department may be a part of a comprehensive rehabilitation program in which vocational training in many fields is available nearby. For this reason, extensive use of power tools and equipment in the department is unnecessary because this training can be provided in vocational shops.



Treatment Cubicles: This cubicle arrangement, with cubicles enclosed by either sliding curtains or accordion partitions with curtains at the entrances, is recommended. Shelves for supplies and equipment extend up to the height of the enclosures. Each shelf unit has a lavatory, a mirror, and a place to hang clothing. An adjustable spotlight is attached to alternate shelf units. Each cubicle has electrical outlets.

(1) Training Kitchen — This may be a separate room but may be walled off by sliding curtains or folding partitions. It should be equipped with standard kitchen furnishings with only the modifications necessary for individuals in wheelchairs.

  (a) Counter surface should be 30" in height, which is most satisfactory for wheelchairs. However, there should also be a counter 36" high (standard height) so that the individual may learn to use this if possible.

  (b) The stove controls should be at the front or at one side of the stove. The oven should be below or at counter level.

  (c) The sink should be the shallow standard size. Space beneath the sink may be open or may have swing-away doors to permit a wheelchair to approach.

  (d) There should be a washing machine and a dryer.

(2) Training Bathroom — This should be in a separate room. Fixtures should be standard.

  (a) The commode should be accessible from front or from the side with bars by it.

  (b) The bathtub should be arranged with a curtain and grab bars.

  (c) The lavatory should be wheelchair height.

  (d) Showers should be of the roll-in type.

(3) Training Bedroom — This should be curtained off for privacy. The furniture may be standard, except for a bed with a bar overhead.

(4) Shop — There should be a small workshop adjacent to the physical therapy and occupational therapy departments. It is for minor adjustments and alterations in the fitting of prostheses and braces by the prosthetist and orthotist. This workshop may also be used by the physical therapist and occupational therapist.

  (a) A sink with a plaster trap should be provided.

  (b) The shop should have floor room for a workbench, drill press, disc sander, Troutman router, sewing machine, and storage cabinets.

(5) Plaster Room — A room with a sink and plaster trap should be provided.

c. **Fitting Room** — There should be two rooms for measuring and fitting prostheses and braces.

d. **Speech Pathology and Audiology Department** — This department should be located away from sound, vibrations, and passing traffic within the building. It should be located at the end of a dead-end corridor. The walls and ceilings of the treatment rooms should be sound treated, and there should be one prefabricated sound-proof room. Both individual and group treatment rooms with a one-way observation window will be needed.

e. **Clinical Laboratory** — This space should not be located near the speech and hearing department because of the use of a centrifuge. The size of the laboratory is dictated by the work load expected.

f. **X-ray Room** — An X-ray room with a darkroom is necessary. It is for diagnosis, not treatment purposes.

g. **Urology Examining Room** -- This should be located adjacent to the X-ray room in order to use the same darkroom.

4. **Dormitory or Residential Accommodations**

a. **Elevator Service** — These accommodations may be a one-story or multi-story building. If there are more than two stories, elevator service is necessary, but if the building has only two stories, wheelchair cases can occupy the ground floor and others the second floor. Nevertheless, a freight elevator should still be provided.

b. **Individual rooms and bathrooms** — In general, it is best to provide a tub or a tub and shower for female occupants, but showers are almost always preferred by male occupants. Wherever wheelchair persons are housed, tubs should be equipped with curtains, and showers should be of the roll-in type. When wheelchair persons are housed in these accommodations, at least half of the rooms should be made suitable for wheelchair cases.

5. **Food Services**

Cafeteria style food service is preferable, with canteen services available during closed hours. The dining room should be convenient to the student activities area and also near the rehabilitation nursing section so that persons in this area can eat in the general dining room. The dining area should not be planned for use as an auditorium.

6. **Recreational Activities Center**

a. **Auditorium** — This area should include an auditorium with provisions for wheelchair access and seating. There should be space for 35mm movie projection equipment. The stage should be fully equipped for amateur theatrical productions, and the auditorium should be large enough to accommodate the entire staff and student body.

b. **Activities** — This area should offer a wide range of crafts and both indoor and outdoor recreational activities. The activities should include highly active as well as sedentary sports. Activities should be suitable for both wheelchair and ambulatory indviduals.

7. **Vocational Training**

   a. **Construction** — The entire area should be accessible to wheelchair individuals as well as ambulatory cases. The training areas or buildings should be constructed to permit maximum flexibility of use in regard to size of classes and techniques of training. Removable modular partitions not reaching the ceiling should be used as much as possible. Permanent divisions between "clean" and "dirty" areas and between "quiet" and "noisy" areas will be necessary.

   b. **Wiring and Plumbing** — Electrical wiring and all plumbing should be as easily accessible as possible throughout the training area. This permits change of any area with a minimum of alterations.

C. SUMMARY

In summary, it should again be pointed out that facilities in different localities will probably vary a great deal in the physical plant. However, there are certain basic architectural principles which might be applied to a comprehensive rehabilitation center, a rehabilitation unit in a hospital, or any facility designed to help the disabled.

ED039317

MENTAL HEALTH REHABILITATION SERVICES

IDEAL SERVICES SERIES

VOLUME II

EDITED BY

STANLEY I. HOLZBERG, M.D.

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STATE DEPARTMENT OF EDUCATION
Division of Vocational Rehabilitation
Rehabilitation Facilities Section

Tallahassee, Florida

June, 1968

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PREFACE

This volume, the second of the Ideal Services Series, is concerned with rehabilitation services for the mentally ill. It is an outgrowth of the Workshops and Rehabilitation Facilities Planning Project initiated by the Division of Vocational Rehabilitation in July, 1966, and it will be presented as a guide to all interested persons involved in Rehabilitation Facilities Planning.

In spite of tremendous efforts and significant gains made in the field of mental illness, the gap between supply and demand widens at an alarming pace. Many obstacles have obstructed the prevention and treatment of mental disorders and the rehabilitation of persons afflicted with this disability. Many movements and specialized groups, uncoordinated and divided by different ideologies and goals, have toiled in divergent or overlapping directions.

Perhaps the greatest impetus to collective or community action in behalf of the mentally handicapped came as a result of the Economic Depression of the 1930's and also World War II. The former period witnessed a change in the role of government in meeting social needs, and the latter event tragically portrayed the extent of emotional illness as reflected in the unfitness of many Americans for military service. In an effort to organize comprehensive and coordinated services for every citizen in need, in 1963 Congress passed the Community Mental Health Service Act. This act was intended to stimulate and assist the states in the construction of comprehensive community mental health centers.

The concept of community services includes not only the responsibility for prevention, treatment, and rehabilitation of mental or behavioral disorders, but a re-evaluation of techniques utilized by various social institutions. In order to meet the challenge and opportunities presented by psycho-social problems, cooperation and coordination between individuals and institutions in the public and private sectors of our society is mandatory. It is with such intent and spirit that this volume is written.

I wish to acknowledge a number of persons who have been helpful in the preparation of this guide. Appreciation is expressed to Dr. R. C. Eaton, Director, Community Facilities and Services, Division of Mental Health, and members of his staff for reviewing the guide. Others who made helpful suggestions were Gerald E. Cubelli of the Psychiatric Rehabilitation Center at Harvard University.

Gratitude is also expressed to Mr. Craig Mills, Assistant Superintendent, Division of Vocational Rehabilitation, and Mr. William J. Miller, Director, Workshops and Rehabilitation Facilities Section, Division of Vocational Rehabilitation, for their constant encouragement and support.

Special recognition goes to Mr. William F. Twomey and Mr. D. Allen Brabham, State Supervisors, Rehabilitation Facilities Section, Florida Division of Vocational Rehabilitation, and Doris W. Hewitt, Assistant Professor, Sociology, Saint Andrews College, Laurinburg, North Carolina. These persons devoted many months to the preparation, writing, and editing of the manuscript.

Stanley I. Holzberg, M. D.
Coral Gables, Florida

LIST OF CONTRIBUTORS

STANLEY I. HOLZBERG, M.D. (Editor)
Psychiatric consultant, Disability Determination Section, Division of Vocational Rehabilitation, State Department of Education

Psychiatric consultant, Workshops and Rehabilitation Facilities Planning Study, Division of Vocational Rehabilitation

Faculty, University of Miami School of Medicine

Florida Psychiatric Society, Rehabilitation Committee.

D. ALLEN BRABHAM, B.A., B.D., M.R.E.
Coordinator, Workshops and Rehabilitation Facilities Planning, State Department of Education, Division of Vocational Rehabilitation, Tallahassee, Florida.

DORIS W. HEWITT, PH.D.
Assistant Professor, Sociology, Saint Andrews College, Laurinburg, North Carolina.

RICHARD L. SAMPLE, B.S.
State Supervisor, Vocational Rehabilitation Programs in Institutions, State Department of Education, Division of Vocational Rehabilitation, Tallahassee, Florida.

WILLIAM F. TWOMEY, B.S., M.S.
State Supervisor, Vocational Rehabilitation Programs in Community Mental Health Centers, State Department of Education, Division of Vocational Rehabilitation, Tallahassee, Florida.

ENDORSEMENTS

I have read Volume II, Mental Health Rehabilitation Services, of your Ideal Service Series, with considerable interest. As far as I know, there is no other comparable document available anywhere which discusses the many complex problems of community mental health in such a comprehensive way. Still, you have achieved your objective of clarity to a lay audience.

It seems to me that local groups could find within this document helpful answers to questions they might have about the mysteries of mental illness and the people who serve them. Yet, you have left to the local group all decisions as to what they feel is best for their community. You also have not tried to tell them what steps to take in community organization.

Gerald E. Cubelli
Research Associate and Rehabilitation
Coordinator
Department of Psychiatry
Harvard Medical School
Harvard University

This is the most comprehensive and concise statement of mental health services under one cover that I have read. It should be within easy grasp of every individual, lay and professional, who is concerned with the mental health welfare of his community, state, and nation.

Edd T. Hitt
Executive Director
Mental Health Association
of Florida

CHAPTER I

UNDERSTANDING THE MENTALLY ILL

Doris W. Hewitt, Ph.D.

A. WHO ARE THE MENTALLY ILL?

1. Traditional Concept of Mental Illness

In times past the mentally ill were commonly called "mad men," "maniacs," "lunatics," and "crazy people." A stigma was attached to mental illness because this disease was viewed with great superstition and distrust. The "insane" individual was believed to be possessed by demons, probably as the result of sin; and public opinion held that the condition called for apathy, punishment, and isolation. Gradually, this concept of mental illness changed as daring physicians treated the emotionally disturbed with greater understanding and freedom and, in so doing, discovered that the mentally ill could often improve.

2. Modern Concept of Mental Illness

As the area of mental health was given more attention, people came to realize that the mentally ill are not only those who have hallucinations and hear imaginary voices, but also persons with other kinds of unusual behavior. It was not until recently that the meaning of "mental illness" broadened to include persons with brain damage, psychophysiologic disorders, psychoneuroses, and personality disorders, in addition to psychotics and epileptics. These illnesses encompass sexual deviations, alcoholism, drug addiction, learning disturbances, and a wide variety of anxiety and depressive reactions. As can be seen from these categories, the concept of mental illness has taken on a much broader meaning than it had traditionally.

a. **Psychosis** — The psychotic is a person who has often lost contact with reality and can no longer perceive and test reality or integrate it. Since he is unable to deal properly with reality, he sometimes takes flight into a world of his own design—a world of fictitious personalities and delusions.

b. **Psychophysiological Conditions** — Some mentally ill persons have problems which originate from clearly-defined organic causes, as in the case of persons who have brain damage. However, it is often impossible to distinguish physical from emotional origins. A large number of physical symptoms commonly have psychological roots, and these disorders are called psychophysiologic.

c. **Psychoneurosis** — A person with a psychoneurotic disorder attempts to handle anxiety which he experiences through means such as conversion reactions, phobias, compulsions, and depressions.

d. **Personality Disorder** — An individual with a personality disorder copes with frustrations in ways which are socially unacceptable and perhaps dangerous to others or to himself. He may be passive or extremely aggressive, practice deviant expressions of sexual urges, or infringe on the rights of others for his personal gain.

3. Relative State of Mental Illness and Mental Health

"Mental illness" is the absence of "good mental health," and both of these terms are relative. The two form a continuum, and every individual falls somewhere between the two extremes. Everyone deals daily with certain tensions and anxieties, and every person is "mentally ill" to a degree in that from time to time he is unable to solve problems in a realistic, wholesome manner. One's position on the mental health continuum varies as he faces crises and is called upon to make adjustments to new situations. Every human being needs support from others, but during periods of crisis and maladjustment when one fluctuates in the general direction of mental illness, he may need more support from others than usual. We have all experienced anxiety, restlessness, uneasiness, inability to perform as usual, and even physical symptoms. It is sometimes difficult to draw a line between those who need professional help and those who will adjust after additional support from friends who may help them resolve their problems. Also, it is difficult to know exactly how to handle certain types of mental illness, particularly since insufficient services are available for the purpose of treatment and care.

B. THE ORIGINS OF MENTAL ILLNESS

There are many physical, psychological, and social theories regarding the origins of mental illness. It is not relevant to the purpose of this publication to explain or even specifically mention these theories. However, two environmental aspects of the origins of mental illness deserve consideration as a community plans ways of preventing mental illness and treating the mentally ill.

1. The Context of American Society

Our society has moved from a relatively simple rural and familial way of life to the complex hustle, bustle, and keen competition of an urbanized society. While the former rural existence afforded most individuals with a number of long-lasting, stable, loving relationships with family members or the closest neighbors, the urban way of life often does not do this. Today, people are usually less dependent on each other economically than they used to be, and they often become too emotionally independent of others and tend to be isolated. The United States has a high rate of social and geographical mobility, so that few relationships are nourished to a deep level and over a long period of time. Anxiety is usually experienced when one fears such things as failure, loss of love, punishment by others, and being unacceptable to others—fears which often seem intensified by certain aspects of industrialized society.

2. Marriage and Family Conflicts

An individual may develop both conscious and unconscious insecurity and negative attitudes about people, marriage, or one sex in particular as the result of marital and familial conflicts. Childhood feelings such as these make relating normally to persons of the opposite sex and adjusting to marriage very difficult later in life. A person with childhood family problems is more likely than others to marry hastily and at a very young age or to select a marriage partner unwisely, thus heightening his anxiety, negative attitudes, and unsatisfactory relationships. The family unit holds great potential for preventing and treating mental illness, but it has equal potential for hurting and destroying one or more persons who are within its framework.

C. A REALISTIC GOAL FOR THE MENTALLY ILL

1. No "Cure"

A defeatist attitude has been adopted toward mental illness by perhaps the majority of laymen and by many professionals because they have learned that the mentally ill cannot simply be "cured." Except for a few cases in which drugs seem to be helpful, progress with the mentally ill is hesitating and slow. We say that the mentally ill person has been "rehabilitated" whenever he or she is able to achieve a satisfactory level of adjustment to the home and community environment. Even then, the mentally ill person is likely to experience a gradual regression if his living situation is undesirable, or he may suffer a sudden relapse in the face of a crisis. He will probably never be able to adjust to changes as readily and painlessly as persons with better mental health.

2. Marginal Adjustment

Life can be made much more pleasant and meaningful to the mentally ill person and to those around him. A "cure" is impossible because this term implies perfect mental health, a condition elusive to us all. But an adjustment is usually possible, and it implies the person's being able to live a fairly normal life alongside his family and friends. This, then, is a realistic and worthwhile goal.

3. Employment

The goal of adjustment includes the person's being able to find employment, even if it must be in a sheltered situation, and to adjust to work satisfactorily. Work is significant in restoring the mentally ill, for in our society there is no single situation potentially more capable of meeting one's basic needs than employment. Work provides money, and money buys food and drink, housing, clothes, medical insurance, and other items which help the individual gain independence and become more responsible. When one works with a congenial group or becomes part of an organization, belongingness is achieved. Work is a symbol of adulthood. It brings status; in fact, social and economic status depend more on one's occupation than any other factor. Real work calls for a degree of independence, cooperation with other, following instructions, and carrying out assigned roles and functions. It provides real rewards—pay, opportunities for status, approval, and fringe benefits. Most important, satisfactory job performance involves learning and understanding and is very important in one's respecting himself and gaining self-confidence.

4. Importance of a Realistic Goal

This goal of satisfactory adjustment to the home, work, and community setting should be the goal toward which the mentally ill person, his family, the counselor, and others work. If they expect less than this due to lack of hope and confidence, they will probably achieve much less. If they expect more, they are likely to be disappointed and become discouraged, thus falling short of even a realistic goal.

D. THE PREVALENCE OF MENTAL ILLNESS

Mental illness affects approximately one of every four Americans at some time during life. It has been estimated that Florida had about 53,000 mentally ill persons in 1966 and that this number will increase to 64,000 by 1970. About 26,000 of these received services from various facilities in Florida in 1967, while more than 5,000 additional persons were waiting for services. These figures point up the great need for more adequate services for the mentally ill.

E. COMMUNITY RESOURCES

The role of the community in rehabilitating the mentally ill person simply cannot be overemphasized. This is true whether the ill person has a personality disorder, psychosis, or some other diagnosis of mental illness.

1. Problems Involved in Removing the Mentally Ill Person from His Community

A healthy individual does not live in isolation, but is involved in the give-and-take of the community in which he lives. When it is necessary to send the mentally ill away to a state hospital, the rehabilitation process will usually become more difficult for him.

> "Hospitalization itself is a direct indication of failure — failure to adjust, to solve the problems of life, to maintain emotional and intellectual stability; the patient himself is keenly aware of this. He has an increased sensitivity to the words and actions of people and their real or imagined attitudes toward him. In our society failure is not just an event, but a reflection on the personal worth of the person who fails. His self-respect and self-esteem are grievously hurt. He needs to feel worthwhile, successful, and accepted, but his obvious failure makes this difficult or impossible. The emotionally handicapped person needs experiences of success to remedy this failure. . . . In the hospital, most decisions and even the routine of daily living are determined by people other than the patient; his self-confidence diminishes as his feelings of dependency increase. For patients who have always felt somewhat inadequate, this experience further weakens their sense

of personal capability. This trend must be reversed as they move back into community living."[1]

2. Value of the Community Setting

The community is the most realistic environment in which to conduct rehabilitation, because the mentally ill person is involved in the real-life setting in which he must learn to function acceptably. If he is able to remain in the community and to receive the type of care which he needs, the prognosis is good. However, if he remains in the community but does not receive the services he needs, he is unlikely to ever improve substantially.

F. SUMMARY

In recent years, mental illness has been much better understood than at any previous time in history. The modern concept of mental illness is broad, and it includes a wide variety of mental and emotional disturbances. Mental illness is so prevalent that it behooves any community to plan and develop services for its mentally ill. Of course, a small town cannot possibly provide as wide a range of rehabilitation facilities and services as a city; however, it can begin planning and gradually increase the services offered as its population and the demand for these services grow.

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[1] Lloyd E. Fish, "Needs of the Emotionally Ill," *Journal of Rehabilitation*, 17, No. 5 (September-October, 1961), p. 24.

CHAPTER II

REHABILITATION PROGRAMS IN MENTAL INSTITUTIONS

D. Allen Brabham

Richard L. Sample

A. ROLE OF REHABILITATION PROGRAM IN THE MENTAL INSTITUTION

Vocational Rehabilitation services have been part of Florida's mental institutional programs for a number of years. Rehabilitation services have increasingly become a more meaningful aspect of institutional programs as the latter have emphasized custodial care less but intensive treatment and rapid return of the patient to the community more. The ideal rehabilitation program has seldom, if ever, been attained; but trends are moving toward greater independence on the part of the institutionalized patient. Perhaps someday mental hospitals will be called "rehabilitation facilities."

B. PURPOSE

State hospital programs should be designed to provide comprehensive treatment and services for the purpose of meeting the total rehabilitation needs of each patient. When the comprehensive rehabilitation program is well planned and coordinated, patients are able to adjust better socially and vocationally, and adjustment is more satisfactory both in the hospital and after returning to the community. The basic goal of the hospital personnel should be to prepare the patient for returning to the community. The rehabilitation program should be geared toward motivating the patient and equipping him with important social and vocational skills.

C. SERVICES

A comprehensive rehabilitation program in a mental institution includes all the services needed to help each patient attain optimal adjustment. To one patient this may mean learning to care for himself, while to another it may mean being trained in some skill or professional occupation. Self-care or vocational and social success mean self-confidence, maximum independence, self-acceptance, and motivation to develop one's potentials to the fullest level possible. Services which should be provided in all mental hospitals are:

1. **Medical Services**

Most mental hospitals are large and rather isolated and are communities within themselves. Therefore, routine medical and surgical services are usually found within the hospital. Medical information is helpful not only to the medical staff, but also to personnel of other disciplines. For instance, recreational therapists, industrial therapists, and rehabilitation counselors frequently utilize the medical reports.

2. **Psychiatric Services**

Psychiatric services usually involve an examination, evaluation, and treatment. Treatment such as chemotherapy and psychotherapy are used.

3. **Admission Services**

The admission procedure and personnel should communicate to the patient that plans are already being made for his return home to his family and community. The admission process should be the beginning of the patient's rehabilitation.

4. **Referral Services**

An ideal referral program necessitates an efficient system of exchanging information, educating all staff members, and the administrative and clerical staff being rehabilitation-oriented. It is the need for rehabilitation services, not the degree of sickness, which should be the criterion for referral. [1]

5. **Psychological Services**

Testing, group therapy, and individual counseling are the psychological services needed in the ideal rehabilitation program in a mental hospital. The tests administered should measure emotional stress, mental ability, academic achievement, interests, and aptitudes. A practical interpretation of these tests should be made in regard to the patient's treatment, rehabilitation potential, and vocational plans.

6. **Social Services**

Information on the patient's social, economic, family, and community background should be secured upon admission. It is usually preferable to obtain this information from the family. This type of information is helpful to the psychiatrist, psychologist, occupational therapist, work evaluator, and other members of the staff. Social services should emphasize the casework process and educating members of the patient's family in regard to mental health.

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[1] Gerald E. Cubelli, John Levis, and Leston L. Havens, M.D., "The State Mental Hospital and the State Division of Vocational Rehabilitation," p. 4.

7. Occupational Therapy

Occupational therapy is more than diversional activity for the extremely ill mental patient. Occupational therapy should develop self-care skills and should help assess work attitudes, skills, and tolerances.

8. Vocational Services

Vocational services should include the various services discussed below.

a. **Counseling** — Vocational counseling consists of assessing the vocational strengths and weaknesses of a client, helping him overcome weaknesses when possible, developing a rehabilitation plan with the client, and helping him attain rehabilitation goals.

b. **Work Evaluation** — Work evaluation is the process of determining a client's vocational assets and liabilities through astute observation of the client as he performs work samples, work assignments, or job try-outs.

c. **Pre-Vocational Training** — Pre-vocational training should be available to hospital clients, when necessary, to develop rudimentary skills such as reading, writing, and mathematics which are basic to vocational adjustment and achievement.

d. **Personal Adjustment Training** — Personal adjustment training is placing the client in certain well-defined experiences designed to correct the work liabilities or negative behavior defined in work evaluation. Reinforcement techniques, monetary ego reward, emotional support, etc., are used to achieve proper personal adjustment.

e. **Occupational Training** — This is also called vocational training and is usually training which cannot be obtained in vocational or academic schools because the client does not qualify or the client cannot attend vocational schools. Brush-up training, such as clerical, etc., should be available so that clients do not lose their skills or work tolerances while hospitalized.

f. **Industrial Therapy** — This program should be a work assignment program to evaluate the total work ability of a patient based upon competitive norms. Clients are usually placed in specific job assignments in various departments of the hospital in order to evaluate their work potential.

g. **Group Work** — This service is usually conducted by the vocational counselor and concerns preparation of the patient for work. Such subjects as applying for a job, the relationship of medication to work, and telling the truth about hospitalization are discussed.

h. **Pre-Release Planning** — Since the purpose of a rehabilitation program in the hospital is to prepare patients for community life, pre-release planning is a must. All plans that meet the rehabilitation needs of the patient in the community must be made with the health nurse, vocational counselor, family, workshop, halfway house, employer, etc., well in advance of the release of the patient.

i. **Transfer of Case File** — There should be no delay in sending the case file to the proper persons, agencies and/or organizations in the community. A system should be developed in the hospital whereby information is automatically channeled to the responsible persons in advance or at the time the patient is released. This information should include address, phone number, relatives, type and dosage of medicine, family doctor, all necessary information and records from the hospital, the rehabilitation plan for the client, and who is responsible for every phase of the client's rehabilitation in the community.

9. Remotivation

This is a program in which acutely ill mental patients meet in regularly scheduled groups where subjects of common interest are introduced and discussed. The interaction between the group members motivates the regressed, withdrawn patient into group participation and interest in his environment. Remotivation groups can be conducted by patients, aides, ward attendants, nurses, and other staff members under direction of the psychiatrist.

10. Group Therapy

Patients may gain insight into their personality problems, emotional weakness, etc., but re-socialization, self-worth, self-confidence, self-acceptance, etc., are also goals of group therapy. The psychiatrist, trained psychologist, and trained social worker should conduct group therapy.

11. Psychodrama

Psychodrama is a form of role playing with a trained therapist (usually a psychiatrist) where the patient is allowed and encouraged to express and act out feelings of any nature. One or a number of patients may participate at one session acting out the event(s) that precipitated hospitalization. Applying for a job, sibling or parent relationships, etc., are common scenes in psychodrama.

12. Recreational Services

Recreational activities should be aimed at more than play as important as play is to good mental health. Recreation should be concerned with development of proper personality adjustment; creative interpersonal relations; the value of competition, relaxation, physical exercise; personal worth; and appreciation of others.

13. Music Therapy

Music therapy may be included in recreational therapy, but it should be a part of the comprehensive rehabilitation program. Such activities as participation in band, orchestra, singing, listening to music, and music appreciation groups have cultural and esthetic values which enhance the mental health of patients.

14. Staffing

Diagnostic, discharge, departmental, and inter-departmental staffings, although not a direct service to or for the rehabilitation of the client, are indirectly services for the client. The client should be the focal point in staffings, and it is here that the team members from various disciplines must give and receive information and develop rehabilitation plans tailored for the patient.

D. PERSONNEL

1. Administrative

A superintendent, administrator or medical director, and a clinical director are necessary personnel to give an ideal rehabilitation program in a mental hospital its proper perspective. The superintendent is personally responsible for administering the organization, finances, operation and public relations of the hospital. The clinical director gives direction to the medical staff and is responsible for all medical treatment, policies, and records.

These persons should possess a thorough knowledge and philosophy of rehabilitation. An understanding of the proper relationships between the medical staff and non-medical staff would be considered ideal.

2. **Medical**

   a. Internists
   b. Psychiatrists
   c. Surgeons
   d. Ophthalmologist
   e. Otolaryngologist
   f. Radiologist
   g. Dentist
   h. Others — As needed as consultants or on the staff

3. **Paramedical**

   a. **Psychiatric Nurses** — Nurses should have special training in psychiatric nursing.

   b. **Occupational Therapist** — Occupational therapists should have special training in assessing work skills, activities, and tolerances; and teaching self-care, activities of daily living, arts, and crafts.

   c. **Speech Pathologist and Audiologists** — The speech pathologists should be competent to work with all speech problems. The audiologist should be competent in audiological evaluation, hearing aids, and training in the use of hearing aids.

   d. **Laboratory Technicians** — Laboratory technicians must be capable of conducting all tests in the medical treatment of patients.

   e. **X-Ray Technicians** — The X-ray technicians should be competent in all X-ray diagnostic procedures.

   f. **Pharmacists** — The pharmacist should order and dispense all medications.

   g. **Recreational Therapists** — The recreational therapists should be well trained in group dynamics, personality adjustment, and have a basic knowledge of games, crafts, and entertainment.

   h. **Music Therapists** — The music therapist should be trained in the use of music as treatment for the mentally ill.

i. **Psychologists** — This person must be skilled in administration of various tests. Vocational interpretation of the tests is a very important function of the psychologist.

j. **Social Workers** — This person should be trained in all the aspects of psychiatric social work with emphasis upon the family.

k. **Medical Records Librarian** — This staff member must be competent in methods of record keeping, coding, diagnosis, filing systems, etc.

4. **Vocational**

a. **Rehabilitation Coordinator or Supervisor** — This staff person should be the supervisor over the vocational rehabilitation staff and should coordinate all rehabilitation services for the patients.

b. **Rehabilitation Counselors** — This person must be competent in assessing the vocational needs of patients. He will utilize all other necessary services to gather information relative to the vocational rehabilitation plan for patients.

c. **Work Evaluator** — This is a skilled person in the use of work samples, job try-out, industrial therapy assignments, etc., to determine the physical, social, psychological and vocational weaknesses and strengths of the patient.

d. **Personal Adjustment Teacher** — This person should have a high degree of skill in modifying the behavior of patient-clients by the use of specific, planned experiences to which patients are exposed.

e. **Industrial Therapist** — The industrial therapist is a person skilled in evaluating a patient's performance in a given job assignment. He also corrects behavior and may be responsible for some training.

f. **Pre-Vocational Teacher** — This person should be competent in remedial education.

g. **Occupational Skill Teacher** — This teacher should be an accomplished mechanic in his occupational area and possess the ability to teach.

5. **In-Service Training**

The hospital should have an in-service training program for its entire staff. This training may be conducted inside the hospital or staff members may be sent to various institutes, workshops, and conferences that would enhance their skills in serving patients. A full-time in-service training staff person is a must.

6. Professional Organizations

Each staff member should belong to the professional organizations which represent his profession. Since many disciplines are related, belonging to two or more other professional organizations is always desirable for educational purposes.

E. HOSPITAL - REHABILITATION PROGRAM RELATIONSHIPS

1. Planning

Planning a new comprehensive rehabilitation program in a mental hospital where vocational rehabilitation is involved suggests that the directors of divisions, the clinical director of the institution, the district director of the local vocational rehabilitation office, the department heads of the hospital, and the hospital vocational rehabilitation counselors should be present for the planning and developing of any agreement necessary. All levels of administration and supervision should meet, discuss, and agree upon any major change in the rehabilitation program after it is in operation. Experience has proven that spoken or written directives to the lower echelon of supervision do not establish the understanding necessary for a successful rehabilitation program.

2. Hospital

Most mental hospitals are communities within themselves and are accustomed to its mode of operation. Each institution functions as an autonomous and unique social system and will differ in the operation of its total treatment program. The subdepartments and unit operations within this system will also function differently and be influenced by the hospital's philosophy, patient load, number of staff, geographical location, tradition, and policies. The hospital needs to understand rehabilitation's eligibility requirements, the need for specialist examinations, the need for full access to records and information, etc.

The hospital must help rehabilitation staff to understand the functions of each of its staff activities and encourage both the rehabilitation staff and hospital staff to coordinate services for the rehabilitation of the client.

3. Rehabilitation

The rehabilitation staff assigned to the institution will most likely be community-oriented persons and will find it difficult to understand the philosophy, policies, and procedures of the hospital. Continuous education of the institution's staff by the rehabilitation staff is a necessary and vital process. Within the framework of the hospital system and its treatment program activities, the rehabilitation staff and program must become an integral part of the hospital system through good communication, understanding, and cooperation. No better means of understanding can be developed than the discussion and planning around individual patients in staffings or between individual staff persons.

Rehabilitation personnel must remember they are invited guests in the hospital "community." The rehabilitation staff will be considered outsiders frequently until hospital personnel and rehabilitation staff understand each other.

F. COMMUNITY - REHABILITATION PROGRAM RELATIONSHIPS

It is not good enough to have a comprehensive rehabilitation program in the hospital. The success of the hospital program can only be measured in terms of the community adjustment of the patients. Therefore, the hospital program must be extended to the community. Since the state is too large for the hospital rehabilitation staff to follow each patient into the community, personnel and services of agencies, organizations, and facilities must be utilized in the communities. The vocational rehabilitation staff in the hospital must use community vocational counselors. Vocational counselors, mental health workers, health nurses, social workers, psychologists, etc., should visit hospital rehabilitation programs and learn the importance of their cooperation. Likewise, hospital staff should visit communities to which the majority of patients return. This will give the hospital staff a thorough understanding of what services are available in the communities and how best to prepare the patient-client for community adjustment. A plan of communication must be established to insure community relations that will assure a continuum of services for patients.

CHAPTER III

REHABILITATION FACILITIES

Doris W. Hewitt, Ph.D.

William F. Twomey

A. A NEW APPROACH TO MENTAL HEALTH

1. Appropriations for Action in Mental Health

At no time in history have so many individuals made such vast efforts to benefit the mentally ill and to assure their well-being once health is restored. The late President Kennedy took the initiative in encouraging and directing the interest in mental illness and mental health that had been building up for over a decade. In response to his request, in 1963 Congress appropriated $4.2 million to be distributed among the various states over a two-year period as grants-in-aid. These funds were made available for the sole purpose of planning community-centered mental health activities to meet the needs of citizens.[1]

2. A Concept of Community Mental Health

From this and other efforts evolved the concept of community psychiatry and the community mental health center or program. Basic to these concepts is coordinating the efforts of agencies which have heretofore served the mentally ill as independent bodies with over-lapping services. Vocational Rehabilitation personnel, general hospital staff, private psychiatrist, and others must realize their vital functions as parts of the Community Mental Health Program and join hands in a cooperative effort toward providing more comprehensive and effective services.

3. Responsibility of the Division of Mentally Health

Of course, the integration of numerous resources presently available to aid in the prevention, treatment, and rehabilitation of persons with mental illness is a large and necessary task. The

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[1] Florida Mental Health Advisory Planning Council. *The Florida Plan for Mental Health* (Jacksonville: Florida State Board of Health, 1965).

Division of Mental Health has been assigned the responsibility of exercising executive and administrative supervision over all institutions, programs, services presently existing or acquired, and those established under the jurisdiction of the Division of Mental Health in the future. The Division of Mental Health is responsible for planning, developing, and coordinating a complete, comprehensive state-wide program of mental health which will include community services, child services, state mental institutions, research, and training. The Division of Community Hospital and Medical Facilities is responsible for administering the federal Hospital and Medical Facilities Amendments of 1964 (Florida Law Relating to the Mentally Ill and the Mentally Retarded, 1965, Title XLVII).

B. COMMUNITY PROGRAMS AND FACILITIES FOR THE MENTALLY ILL

In working with the mentally ill, Vocational Rehabilitation counselors utilize not only their offices, but also the community mental health center, clinics, halfway houses, other community resources, and various types of other rehabilitation facilities. Following are brief discussions of some of the facilities or programs which every community should either have or have access to for the benefit of its mentally ill.

1. The Mental Health Center

The mental health center is actually more a "program" than it is a "center." It is usually a merger of previously existing services and new services, and these services are generally not located under one roof. The mental health center serves a smaller population area of the state than does the state hospital. It serves a population area of 75,000 to 200,000 persons.

a. **Purpose** — The mental health center plans for and provides a mental health program which meets the needs of the community without duplication of services. It provides for continuity of care, allowing the mentally ill person to remain at home with his family or at least to remain in the community while receiving the treatment he needs. Such a center is responsible for providing services to all community residents, including persons of every age and socio-economic level.

b. **Present Status** — Because mental health centers are basic to the "bold new approach" to problems concerning mental illness, federal assistance is available for the construction and staffing of these centers, and they are rapidly springing up across the state under the direction of the Division of Mental Health. They are largely the result of an effort to replace large state mental institutions.

c. **Services**

(1) **Essential Services** — In order to qualify for federal funds, a center must offer the following five services:

(a) Inpatient treatment
(b) Outpatient treatment
(c) Partial hospitalization services, such as day care, night care, weekend care
(d) Emergency services twenty-four hours per day, available within at least one of the three services listed above
(e) Consulation and educational services available to community individuals, agencies, and professional personnel

(2) **Additional Services** — In addition, those planning for community mental health centers are urged to include these services:

(a) Diagnostic services
(b) Rehabilitation services, including vocational and educational programs
(c) Precare and aftercare services in the community, including foster home placement, home visits, and halfway houses
(d) Training
(e) Research.[1]

d. **Personnel** — The personnel needed largely depends on which of the above services are offered in the center itself and on the size population served.

2. **The Mental Health Clinic**

One of the services which the mental health center must provide is an outpatient service. This service is most frequently provided by a mental health clinic, which may be housed in a separate building or in a building along with other services under the mental health program.

a. **Functions** — The main functions of a mental health clinic are as follows:

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[1] *Ibid.*

(1) **Treatment** — To provide treatment for persons with acute mental illness

(2) **Care for Chronic Mentally Ill** — To care for the mentally ill who are just short of going to a state mental hospital, or for patients who have returned from the hospital

(3) **Headquarters** — To serve as headquarters for mental health consultants who work with counselors and social workers

(4) **Education** — To provide a degree of mental health education. Mental health education should not be left solely to the mental health clinic, but should be the concern of the Health Department, Mental Health Association, and other similar agencies or societies.

b. **Services** — Of course, the types and extent of services offered in the mental health clinic must largely depend on the availability of professional staff and other community resources. Outpatient psychiatric and counseling services must be provided. Other services which may be provided are group therapy, family casework, and mobile clinic services.

c. **Personnel** — Many mental health clinics have long waiting lists due to insufficient staffing. The mental health clinic should have at least a psychiatrist, psychologist, rehabilitation counselor, and social worker, with additional personnel as needed for the services offered.

(1) **Psychiatrist** — The psychiatrist may work in the clinic part-time or full-time. Concerted effort must increasingly be made to induce psychiatrists in private practice to devote a substantial part of their time to working in mental health clinics as consultants and therapists. Most clinics serve both adults and children, although a few clinics exist for adults or children only. Clinics serving only children or a large number of children should have a child psychiatrist, but child psychiatrists are difficult to find. Working with disturbed children and their parents calls for a great deal of patience, and therefore two few people have entered this field to nearly meet the demand.

(2) **Psychologist** — The psychologist may be part-time or full-time. His primary responsibility will be psychological testing.

(3) **Social Worker** — The social worker must be full-time. This person will handle intakes and interviews; make referrals to the psychiatrist or psychologist as needed; and do individual, group, and family counseling.

(4) **Other** — The mental health clinic should ideally have a part-time or full-time marriage counselor—or, if such a person is not available, a family life specialist—on the staff. Other persons who might be included on the staff are a psychiatric nurse, a consulting neurologist, psychiatric aide, volunteers, etc.

(5) **Rehabilitation Counselor** — At least one full-time rehabilitation counselor should be based in the clinic. He will work with the clinic's patients who are eligible for Vocational Rehabilitation services by providing them with counseling and placement services and purchasing medical and training services for them when appropriate.

d. **Type of Operation** — Some mental health clinics are operated as outpatient departments of general or state hospitals. Others are part of a state or regional system for mental health care, and still others are independent private agencies. All three types of clinics have a common goal of reducing the need of the mentally ill for repeated or prolonged hospital care. They provide medication, psychotherapy, and casework services for persons who do not need hospital care but can benefit from regularly scheduled visits with the psychiatrist, psychiatric social worker, or other professional workers in the field of mental health.

3. The Walk-In Clinic

In addition to the typical mental health clinic, there are other clinics which render services to the mentally ill. One of these is the walk-in clinic, which has become more and more prominent in recent years. This type of clinic is as the name implies; that is, people simply walk into it off the street without having made an appointment and without necessarily having been to the clinic before. Some of these clinics, such as those operated by a hospital, operate on a full-time basis and are in a permanent location. More often, however, they are part-time in any given location and move from setting to setting throughout the week or month.

a. Purpose

(1) **Walk-In Clinic** — The walk-in clinic housed in a permanent setting primarily provides emergency services, although it too should be located in an area where services to the mentally ill are inadequate. Many persons who need help will seek it when confronted with an open-door, walk-in sit-

uation but would never make formal arrangements to seek help.

(2) **Mobile Walk-In Clinic** — The mobile type of walk-in clinic fulfills two main purposes:

(a) It serves disabled people who live in areas where the services they need are inaccessible. For instance, the clinic team might spend two days each week outside the permanent facility, perhaps half a day at four different rural or slum communities. The residents of these communities know that the team will be at a certain location at a particular time each week to treat people who drop in.

(b) It provides emergency services to the acute mentally ill.

b. **Personnel**

(1) **Walk-In Clinic** — The clinic team should consist of a minimum of a psychiatrist, social worker, and psychiatric nurse.

(2) **Mobile Walk-In Clinic** — The mobile team are often regular employees of the mental health clinic or some other facility, and on certain days they become a mobile unit and are on duty at various sites.

4. Day Care and Night Care Services (Partial Hospitalization)

Another service which the mental health center must offer is partial hospitalization such as day care, evening and night care, and weekend care. Partial hospitalization services indicate an important trend in modern psychiatry which may someday be a major therapeutic vehicle for severe mental illness. Day services are more commonly available than evening or night services. Evening and night services are usually provided by a day care hospital which is staffed around the clock.

a. **Purpose** — The purpose of the day care or night care program is to treat mentally ill persons without necessitating full-time hospitalization. In the case of day services, patients spend all day in the center or hospital and return to their homes in the evening. In the case of night services, patients usually work part or all of the day and then go to the center in the evening for treatment and various activities. They spend the night and eat breakfast there. Evening care patients are able to work during the day and spend the night at home, but need sustaining help at least one or two evenings a week. Evening care and night care services offer several special advantages. Persons receiving such care need not disclose their patient status if they prefer not to, and this means that more persons who need help would seek it under these circumstances. Night care does not interfere with work or social life, and it is a means of providing emotional support to patients while they are adjusting to employment.

b. **Types of Persons Served** — Day care services are designed for patients who need treatment but who do not need to stay in bed or to remain in a hospital until they are completely well. Persons with all types of mental illness may be treated in a day hospital. This includes both men and women, persons with both chronic and acute conditions, and the severely-ill psychotic. The Day Hospital in the Massachusetts Mental Health Center is a center which might serve as a model for other centers. A study of its Day Hospital revealed that sixty-nine per cent of the patients being served at that time had been diagnosed as psychotic and that the large majority of these were classified as schizophrenic. All levels of severity of mental illness were observed among the patient population. The average length of stay in the unit did not exceed three months unless there were compelling reasons. Most patients commute to the day care center unaccompanied, and about a fifth of them commuted from distances requiring over an hour of travel back and forth. The patients' ages ranged from thirteen to sixty-eight, with a median of thirty-one.[1]

c. Services

(1) **Treatment** — Medical treatment is one of the main services rendered to the patient who is partially hospitalized.
(2) **Activities** — A broad range of activities are available to the day patient. The activities program arose from a philosophy emphasizing the therapeutic value of the milieu and from the view that healthy components of one's personality could be stimulated and supported by various types of therapy. In the past, the work program was considered to be the most important activity for patients in day hospitals, and there were few other activities. However, today various arts and crafts, games, outings, bowling, and athletics in the hospital gymnasium are all considered to be a vital part of

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[1] Bernard M. Kramer, *Day Hospital: A Study of Partial Hospitalization in Psychiatry* (New York: Grune and Stratton, Inc., 1962), 52-61.

the daily activities. Also, group activities such as social clubs, ward meetings, group psychotherapy, and group counseling are given an increasing amount of attention.

(3) **Family Services** — The problems of community-based patients frequently involve family dynamics. Day care programs have brought to focus the importance of roles played by various family members, and family counseling by the social worker is a necessary service of any day care program. Family conferences conducted with the physician, family, and patient present should be valuable. Frequently, family conferences should be held in the day hospital because improvement on the part of the patient can be greatly enhanced through therapeutic efforts directed toward the family.

(4) **Work Services**

(a) **Group Counseling** — The work program continues to play an important role in day hospitals as it has in the past. In the day care center, the Vocational Rehabilitation counselor has an excellent opportunity to conduct group counseling sessions on such topics as finding employment and adjusting to the job environment. Topics often include how to fill out an application form, how to draw up a resume, what to tell and not tell the prospective employer, types of jobs which are available, general preparation for employment, and adjusting to a new job.

(b) **Individual Counseling** — In addition to group counseling, the rehabilitation counselor may do a great deal of individual counseling. He can help clients begin planning for additional training, further education, or a more appropriate and satisfying occupation.

(c) **Work Evaluation and Actual Work** — The Vocational Rehabilitation counselor should work with the occupational therapist in planning work experiences for patients ready for such activity. Often the general hospital may be utilized for work programs of a limited nature. Progressing beyond these activities, the patient may be sent to a workshop for a more intensive work evaluation, personal adjustment training, or work adjustment training. Experiences of this nature are flexible and can be adapted to meet the needs of individual patients. This is especially necessary in the case of someone who is severely ill. For instance, a work program might begin on an hour-a-day basis and gradually increase according to the tolerance level of the patient. The patient's performance in work programs can be a valuable aspect of both evaluation and treatment. Through experiential participation, it provides a source of information which can be utilized in group therapy or group counseling. The physician is often aided in his treatment program by reports on a patient's progress in such work settings. Certainly work programs lend themselves to the therapeutic milieu concept and are consistent with the basic purposes of day care services.

(5) **Emergency Services** — The night hospital can provide overnight services for emergency psychiatric cases.

d. **Personnel** — Although a few day care services are provided by private centers, such services are most often provided through a "day hospital" which is part of a general hospital. The staff is usually made up of a corps of full-time employees and also "borrowed" personnel whose main duties are centered elsewhere in the hospital. In addition to medical professionals, other persons are involved. For instance, distinct functions are carried out by the nurse, attendent, occupational therapist, social worker, psychologist, and rehabilitation counselor. Their functions and roles often overlap and interchange, and this seems to be desirable. In a sense, the day hospital borrows from all segments of the hospital and, conversely, is integrated into the total hospital program.

e. **Location** — Easy access to an inpatient facility makes it possible to effect smooth transfers to a full-time unit whenever necessary. The physical plant and its convenience are important in making day care or night care most effective.

5. The Halfway House

a. **Purpose** — The halfway house is a transitional residence facility between living at home and being hospitalized. It is a temporary residence for the mentally ill who have been discharged from a mental hospital but are not yet ready to resume independent living. Also, it is used by disturbed persons who are unable to tolerate their home environment and yet do not need hospital care. Halfway house residents live with other patients as they move back into full community life by gradually reestablishing relationships with relatives and friends and by reentering the labor market.

b. **Ways in Which Halfway Houses Differ** — "Halfway houses everywhere are based upon the concept of need to provide a residence in which there is acceptance of the patient as he is, with the goal of strengthening social and personal resources."[1] Despite this common aim, however, there are many differences in halfway houses.

(1) **Types of Persons Served** — Some of them are designed for a specific age group, such as adolescents or young adults, while others are for persons of any age. Although most halfway houses are for persons with any type of mental disturbance, some are for special groups. For example, there are a few halfway houses specifically for alcoholics, addicts, and juvenile delinquents.

(2) **Sex of Residents** — Some halfway houses are for only one sex, while others are for both men and women. It is generally agreed that segregation of the sexes contributes to a less realistic atmosphere and tends to promote separation of the halfway house community from the larger community. Normal daily contact with the opposite sex seems to give the ill person increased motivation and help him achieve resocialization much sooner. If the physical plant is carefully planned, there should be no reason to limit patients to only one sex.

(3) **The Physical Setting and Operation** — Some halfway houses are very small and are designed to replicate a family setting, while others are large and much like a dormitory. A few halfway houses are operated by hospitals or persons in the medical profession and include treatment in their programs. However, the true halfway house does not include treatment; rather, its residents obtain any treatment which they need from other community facilities and services, and the halfway house is merely their "home." Another variant of the halfway house is the subsidized apartment building for recently discharged psychiatric patients.[2] Such facilities as these are usually operated by private groups.

c. **Services** — The services rendered by the halfway house depend primarily on the type of halfway house under consideration. As mentioned earlier, services of a true halfway house do not include treatment; rather, they are centered around social experiences and adjustment programs.

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[1] David Landy and Milton Greenblatt, M.D., *Halfway House* (Washington, D.C.: U.S. Department of Health, Education, and Welfare, Vocational Rehabilitation Administration, 1965), p. 3.

[2] Silvano Arieti, M.D. (ed.), *American Handbook of Psychiatry* (New York: Basic Books, Inc., 1966), Chapter 40.

(1) **Family-Oriented Halfway House** — There are two broad types of ideal halfway houses. First is the smaller, family-oriented facility. It provides a neutral setting in which the patient may benefit from family participation, familial training, personal adjustment training, work adjustment, and resocialization. This type of halfway house should provide for eight to twelve residents, preferably of both sexes. The focus is on the role of the house parents. The program is centered around very basic, unsophisticated group-living experiences such as sharing household duties and relating to group members. This kind of facility is utilized most often by persons, particularly schizophrenics, returning from a mental hospital. It is a very appropriate setting for disturbed young adults.

(2) **Community-Oriented Halfway House** — The second type of halfway house is larger, accommodating twelve to thirty individuals. Its program focus is on work evaluation, work adjustment, and the total community milieu rather than the halfway house "family." This type of facility is more popular than the first type mentioned because it is more versatile. Its residents are more independent and more sophisticated than those of the other type of halfway house. This larger halfway house ideally includes persons of both sexes and with a variety of mental illnesses. Interaction between residents is a major tool in training, and there is less personal adjustment training per se. Most of the residents are in work evaluation or training programs or are already employed, so there is considerable contact with and involvement in the community. Residents are encouraged to join social clubs outside the house. This kind of halfway house is especially effective in working with persons who have not been hospitalized but are receiving medical treatment from community resources and need a neutral environment for a more rapid, complete recovery.

d. **The Problem of Continued Dependence on the Halfway House** — Ex-residents of a halfway house sometimes tend to perpetuate their separation from the community by returning to the facility for their social life. Since the ultimate goal of the halfway house is to return the patient to full community life, this should be discouraged. If an individual needs to return to the house for social activities, he probably ought to be readmitted to the facility.

e. **Administration and Personnel**

(1) **Board of Directors** — Halfway houses are usually operated by an incorporated group with a private board of directors.

(2) **Policy Committee** — There is a policy committee, sometimes called a screening or review committee, which is comprised of key professional people and one or more board members. This committee makes policy decisions, screens patients who apply for admission, and makes decisions concerning a person's length of stay if it goes beyond the usual three to six months residency.

(3) **House Parents** — The house parents are the only full-time personnel. They are usually a couple; and while they sometimes do not reside in the facility, it is preferable that they do live there.

(4) **Other Personnel** — A director is in charge of the facility operation, and under him is a staff composed of one or more social workers, a motivational therapist, and a group worker. These staff members are not usually full-time halfway house personnel but are shared with other community facilities. Sharing the staff in this manner is very helpful in relating the halfway house to other community facilities such as hospitals, the adjustment center, social clubs, clinics, and the mental health center.

f. **The Physical Setting** — The physical setting of a halfway house is important. Of course, it should be attractive and pleasant, and the building should be substantial. Two stories are preferable so that one floor can be used for all residents of each sex. It should be accessible to transportation routes, places of employment, shops, churches, and recreational facilities. In rural communities, a ranch or farm-like setting is excellent if it does not preclude access to these conveniences. If possible, the physical plant should be planned so that each resident has a room of his own.

g. **The Halfway House As Compared with Foster Home Care**— Critics often maintain that the halfway house is too isolated from the home and community and that foster home care is preferable. Foster home care has a number of advantages; however, most mentally ill people cannot identify with a foster family and feel the sense of belonging there which they tend to feel in a halfway house. In a private home they are "outsiders," while the halfway house belongs to one of its residents just as much as to another.

6. The Adjustment Center

a. **Purpose** — The primary purpose of an adjustment center is to rehabilitate the mentally handicapped to productive vocational attitudes relative to personal and social adjustment in the community. The emphasis in this program is on attitude and behavior modification through experiences designed to give mentally ill persons a variety of work, personal, and vocational experiences. These experiences will enable them to effectively utilize additional services offered in the rehabilitation process and achieve optimal adjustment in the community.

b. **Persons Who Utilize the Adjustment Center** — The adjustment center provides an effective program for mentally ill individuals who are deficient in their ability to deal with their social and vocational environment. Individuals who are work-inhibited or have major relationship problems, and yet who can live in a community setting with supportive assistance, are appropriate for an adjustment center program.

c. **Objectives** — The objectives of the personal adjustment center are:

(1) To improve personal skills, self-help, and responsibility
(2) To induce social skills and interpersonal relationships
(3) To increase work tolerance
(4) To improve personal appearance and the self-image
(5) To move the individual toward employability.

d. **Program** — The specific program design for an adjustment center should include academic instruction, activities of daily living in homemaking, personal grooming, recreation, industrial arts, group vocational therapy, vocational exploration and evaluation, and vocational guidance and counseling. An emphasis should be placed on the development of work habits, development of characteristics which will better prepare an individual for employment.

e. **Staff** — Some staff members of the personal adjustment center can be shared with other community programs. For example, the county school system may provide for educational staff; and mental health center or mental health clinic may provide professional people in the area of mental health; the Division of Vocational Rehabilitation district office may provide Vocational Rehabilitation counselors; etc. Also, full-time staff will be needed as the program and administrative policies indicate.

f. **Administration** — The adjustment center may be administered by a non-profit corporation with an appropriate board of directors, a mental health facility, a general hospital, or a rehabilitation facility.

g. **Prototype** — There are several adjustment centers in operation throughout the country; however, the program sponsored jointly by the Mobile Mental Health Center and the Alabama Division of Vocational Rehabilitation appears to be an appropriate prototype. The Mobile Mental Health Adjustment Center provides a laboratory experience for mentally ill people who are socially and vocationally inhibited.

7. Social Clubs

a. **Types of Organizations for Ex-Mental Patients** — A wide variety of organizations for ex-mental patients exists. Among these are mental patient aid societies, which include community leaders as well as the mentally ill and their families; therapy groups, which may or may not be affiliated with a professional group and have a professional leader or consultant; and social clubs, whose activities are of a social and recreational nature. Of these three types of groups, social clubs are probably most common and perhaps most effective.

(1) **Membership** — Some social clubs are limited in membership to the mentally ill or ex-mental patients, while others are open not only to the mentally ill but also to friends, relatives, and other interested persons.

(2) **Meetings** — The clubs are small groups which may meet daily, weekly, twice a month, or monthly. They may meet in a recreational center, a church, an adjustment center, or any number of other places.

(3) **Sponsorship** — Often social clubs are an organized part of the program of an adjustment center, day hospital, or halfway house.

b. **Purpose** — Social alienation is one of the major symptoms of mental disorder; and it is one of the most troublesome symptoms, in light of general community attitudes of prejudice against people who have a history of mental disorder. In the social club shyness, passivity, and inhibitions are dealt with in a sympathetic and understanding manner by fellow members. Social clubs play a vital part in weaning the person from social alienation back to a healthy state of social participation and in helping him tolerate the difficult weekend period. Therefore, they are a valuable part of the therapeutic community. Some more specific goals of social clubs include:

(1) Becoming a member of an understanding group

(2) Overcoming fears in interpersonal relationships

(3) Developing new interests and hobbies, learning about various community resources, and developing individual potentials to a maximum level.

c. **Activities** — Community-based patients and returned patients from state hospitals are in particular need of programs centered around socialization and resocialization activities. Social clubs can be helpful in involving a patient in new social activities which are fun, stimulating, and educational. There may be parties, teas, cookouts, and other activities which will help the mentally ill to learn social skills and to develop pleasant relationships with others. The mentally ill often lose their jobs, in spite of having adequate vocational skills, because they lack skills in getting along with others. The social club setting provides an opportunity to learn new and more appropriate kinds of behavior which can be applied to the employment situation and other aspects of life.

d. **Personnel** — A part-time or full-time director will be needed in addition to the following staff members: a part-time social worker (who may possibly serve as director), a recreational therapist, a group worker, and a motivational therapist. Select volunteers may be very helpful in organizing and carrying out a social club program.

8. The Work-Oriented Facility

Work-oriented facilities are those designed primarily to help the disabled prepare for a job, find an appropriate one, and keep it. A workshop is one type of work-oriented facility. Services related to employment are sometimes provided by facilities other than work-oriented ones but are on a limited basis and are not among the major services offered. For instance, work services are often provided by mental hospitals, rehabilitation centers, and day hospitals. Also, they are provided by private employers in the community.

a. **Purpose** — The work setting often brings about problems which may be precipitating causes of mental illness. An individual who is unable to obtain a satisfactory job suffers from a sense of failure; whether the problem is lack of education and skills; inability to take the proper initiative in seeking a job; ignorance about how to find employment; or making a poor impression due to appearance, speech, or mannerisms. Once a job has been obtained, he may be unable to maintain it because it does not interest him and is not a challenge. He may lose the job because he cannot perform the necessary skills adequately, follow instructions, get along with fellow workers, or abide by established rules. Certain work services are invaluable in preparing the emotionally disturbed person for work, helping him find employment, educating his employer as to what to expect of him, and helping him adjust to his work setting.

b. **Services**

(1) **Work Evaluation and Vocational Evaluation** — The work evaluation and vocational evaluation are two widely used services. They are similar, but vocational evaluation goes a step further than work evaluation in that it isolates appropriate job families, clusters, and specific jobs rather than merely identifying problems and strengths of the client in regard to work. The work evaluation is geared toward developing a vocational prescription for the client. Personal adjustment training, occupational training, vocational evaluation, or other service may be recommended in this prescription.

(2) **Other Services Provided by the Work-Oriented Facility** — Other services available in most work-oriented facilities include those listed below. These services generally overlap to a considerable degree; for instance, a person who is receiving vocational training will be receiving limited "built-in" personal adjustment training at the same time.

(a) Personal adjustment training
(b) Work adjustment training
(c) Vocational training
(d) Individual and group counseling
(f) Environmental therapy
(g) Research
(h) Training

(3) **Actual Work Experience** — One of the most important functions of the work-oriented facility is to provide transitional and long-term work experience. Other work-oriented facilities may provide these work experiences to a more limited degree. Most clients who work in the sheltered setting should be able to maintain a satisfactory job in the competitive labor market later on. Nevertheless, there are a few individuals who are so severely disturbed or handicapped in other ways that

they may never be able to succeed in competitive employment and will need to continue employment in the facility.

(a) Some work-oriented facilities want to keep clients, once they are prepared for outside employment and have achieved a high production rate; but this is a hindrance to the client, and the staff should take deliberate steps to avoid its occurance.

(b) Many work-oriented facilities have made outstanding contributions to rehabilitation by providing a broad range of work services. A typical establishment offers clients work experience and/or training in a wide variety of fields such as sales, cafeteria work, office work, electrical repairs, custodial and maintenance work, transportation, communications, wood and metal repair, shoe repair, sorting and handling material, sewing, shipping, printing, laundry work and dry cleaning, upholstering, assembly line work, etc. Workers receive a salary. In addition, they enjoy coffee breaks, picnics, and other social affairs together. Some of them may live in a residential facility provided by the worshop.

c. **Personnel** — A work-oriented facility which provides the services mentioned above will need the following minimum staff:

(1) Director
(2) Industrial relations specialist
(3) Procurement specialist
(4) Foreman
(5) Medical consultant
(6) Social worker
(7) Psychologist
(8) Vocational counselor
(9) Work evaluator
(10) Personal adjustment teacher
(11) Occupational skill teacher
(12) Secretarial staff — The evaluation reports are very important and should be complete, clearly written, and typed. A sufficient number of secretaries will be needed to assist with these reports.

d. **Setting** — The work-oriented facility should have access to transportation routes. The physical plant and work environment should be structured to approximate working conditions in the normal world.

e. **Multi-Disability Approach** — About a dozen work-oriented facilities programs have been organized in the United States during the past several years to serve psychiatric patients only, some of them under federal grants, but work-oriented facilities usually serve persons with various types of disabilities.

9. The Residential Facility

a. **Purpose** — The residential facility is most frequently a part of a work-oriented facility, although free-standing independent residential facilities do exist. The residential facility may be for persons with all types of disabilities or it may cater to a specific group such as alcoholics or addicts. The residential facility differs from the halfway house in that no house parents are available; the facility is operated by only a manager and residents are on their own. The residential facility is excellent for a mentally disturbed person who has spent some time in a halfway house and is now leaving it but is not yet ready to return to his home.

b. **Physical Plant** — The physical plant should be designed to include both sexes. It is recommended that rooms be large enough for no more than two persons, because this allows for greater flexibility and utilization. When rooms are planned to accommodate several persons, potential residents may sometimes have to be turned away when beds are actually available.

10. The General Hospital

a. **Changing Role** — The role of the general hospital in treating the mentally ill has increased a great deal in importance during the last several years. Professional attention under short-term hospitalization should be available immediately to any person in the community who experiences an acute emotional disturbance. If such attention is provided, an initial onset may be kept under control and a major breakdown thus prevented. Also, the number of persons sent to mental hospitals may be greatly reduced.

(1) **Possible Effects of Commitment to State Institutions** — Being committed to a mental hospital often poses a threat to the individual. Commitment to a typical state mental institution means that one loses his right as a citizen; that he is behind locked doors and perhaps bars; that he is separated from his family and friends; that he may be viewed with suspicion after returning to the community; that his

self-image may suffer a fantastic, belittling shock, and he may see himself as a failure. Once he has been in a state hospital, rehabilitation will probably be a more difficult process. It will most likely be some time before he is as fully involved in community life as he was before having to leave. Finding satisfactory employment will be a greater problem as a result of his having been in a mental hospital and court adjudication may be a painful process for the individual. Most important, his regaining self-confidence and respect is likely to be a gradual, tedious process.

(2) **The Need for Local Provisions** — In light of these factors, it behooves the community to provide programs for the mentally ill in every way possible to eliminate the need for long-term hospitalization outside the community. The Joint Commission on Mental Illness and Health has reported in *Action for Mental Health:*[1]

> "No community general hospital should be regarded as rendering a complete service unless it accepts mental patients for short-term hospitalization and therefore provides a psychiatric unit or psychiatric beds. Every community general hospital of 100 or more beds should make this provision. A hospital with such facilities should be regarded as an integral part of a total system of mental patient services in its region."

b. **Services** — The ideal general hospital should offer the following mental health services: a psychiatric ward having a minimum of twenty beds, emergency services, an occupational therapy program with work assignments, individual and group therapy, individual and group counseling, day hospital care, night care, diagnostic services, research, and training.

c. **Personnel** — These services should be under the supervision of a chief psychiatrist. Other personnel might be either part-time or full-time and would include a psychologist, social worker, Vocational Rehabilitation counselor, occupational therapist, recreational therapist, psychiatric nurse, and psychiatric aide.

d. **Length of Stay** — The general hospital should be equipped to provide care for the mentally ill person as long as possible. However, the expense of such care becomes insurmountable over a period of time, so that if prolonged hospitalization is inevitable, the person will probably have to be sent to an area treatment center or state hospital.

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[1] Joint Commission on Mental Illness and Health, *Action for Mental Health* (New York: Basic Books, Inc., 1961), p. 265.

11. Area Treatment Center

a. Changing Role of the State Hospital

(1) **The Setting** — State hospitals came into existence when it was finally realized that the mentally ill were sick, not evil, and that they needed help rather than punishment. The techniques utilized in a typical state hospital are far superior to earlier means used in dealing with the mentally ill. Patients remain in the same ward over a period of time in order to develop therapeutic relationships with the staff and with other patients. An effort is made to keep wards as comfortable, attractive, and home-like as possible. Group therapy and group activities are usually planned for patients on each ward, and patients are allowed limited access to the institution grounds when this seems feasible.

(2) **The Problems of Size and Location** — The state hospital in its present form is slowly being replaced. The size of state hospitals has been a major detriment to their effectiveness. Patients in state hospitals have often been completely isolated from their relatives and friends because of having to be hospitalized so far away from their home community. Therefore, many of the older, large state hospitals are being converted into smaller "area" hospitals and part of their physical plant being used as rehabilitation centers or halfway houses.

(3) **The Emergence of Area Treatment Centers** — The traditional state hospital is being replaced by intensive psychiatric treatment centers called "area treatment centers." It has been recommended that all new state hospital construction should be devoted to this type of treatment facility and that large hospitals already in existence be converted to intensive treatment centers for patients who are acutely ill or for the chronically ill who have a good chance of improvement.[1] In 1961, the Joint Commission on Mental Illness and Health made the following recommendations:

> "No further State hospitals of more than 1000 beds should be built, and not one patient should be added to any existing mental hospital already housing 1000 or more patients. It is further recommended that all existing State hospitals of more than 1000 beds be gradually and pro-

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[1] *Ibid.*, p. 266.

gressively converted into centers for the long-term and combined care of chronic disease, including mental illness. This conversion should be undertaken in the next ten years." [1]

b. **Services Rendered by the Area Treatment Center** — The area treatment center should provide at least the following services: short-term and medium-term hospitalization; psychological, social, and medical services; physical, occupational, and recreational therapy; nursing services; and Vocational Rehabilitation services.

c. **Personnel** — There should be approximately one staff member per patient; area treatment centers should have no more than 1000 beds and, ideally, they should have only about 200. The staff should include a team of competent psychiatrists led by a clinical director. It is important that they work well together and appreciate the role of other professional people in the rehabilitation process. The clinical team should include such workers as psychologists, social workers, occupational therapists, physical therapists, recreational therapists, industrial therapists, Vocational Rehabilitation counselors, nurses, and attendants. A chief psychiatrist, who is trained in hospital administration, should be in charge. The center's staff should maintain as close contact as possible with various professional workers located within its coverage region.

d. **Location** — These area treatment centers should be located very carefully so that one is within reasonable proximity of any community in the state.

e. **Open-Door Policy** — The area treatment center and even the traditional mental hospital should preferably have an open-door policy. The open-door policy is an essential factor in achieving community tolerance for the mentally ill. It is one of the greatest therapeutic developments of the present generation, perhaps even more important than the tranquilizer. Some of the treatment functions and most of the custodial functions of the state hospitals should be returned to the community, but this can be accomplished only by a change in public attitudes and concepts regarding the mentally ill. Public attitudes cannot be expected to change until hospitals demonstrate the value and safety of community care by becoming open hospitals. This will prove that the mentally ill are not generally dangerous and that they can benefit from greater freedom.

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[1] *Ibid.*, p. 268.

CHAPTER IV

OTHER COMMUNITY SERVICES

Doris W. Hewitt, Ph.D.

William F. Twomey

A. ADDITIONAL ASPECTS OF THE THERAPEUTIC COMMUNITY

No other official or voluntary agency has the mandate and resources for providing the wide range of services offered by Vocational Rehabilitation.[1] Many of these services are provided by rehabilitation counselors but others are purchased from various types of facilities and from physicians, psychologists, and other professionals in private practice. The facilities discussed in the previous chapter are facilities frequently utilized by rehabilitation counselors working with mentally ill clients. This chapter will include discussions of professional persons in private practice whose services are used by Vocational Rehabilitation, and discussions of a variety of agencies and special services which are not purchased by the agency and, yet, contribute a great deal to the therapeutic community.

B. PROFESSIONAL SERVICES PURCHASED BY VOCATIONAL REHABILITATION

1. The Psychiatric Community

a. **Evaluation and Examination** — The psychiatrist in private practice provides evaluations and examinations which document the extent and nature of disability and give a detailed report of the patient's previous behavior. This information, along with recommendations, is very important to the counselor in developing a plan for rehabilitating the mentally ill individual.

b. **Services for Acute and Chronic Mental Illness** — Immediate professional attention should be provided in the community for persons suffering a major breakdown. It is often the psychiatrist in private practice who renders this care to the acutely mentally ill. Also, he provides treatment to patients over a prolonged period of time, handles emergencies, and is on call at the hospital.

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[1] Leston L. Havens, M.D., and Gerald E. Cubelli, "The Psychiatrist and the State Vocational Rehabilitation Agency," *American Journal of Psychiatry*, 123, No. 9 (March, 1967), p. 1095.

c. **In-Service Training** — The psychiatrist may be extremely helpful by assisting with in-service training for counselors. Many rehabilitation counselors have little training or experience in dealing with mental illness, and practical explanations and suggestions from the psychiatrist should enable them to work more effectively.

d. **Referrals** — The psychiatrist makes referrals to the agency and is particularly helpful in this respect if he thoroughly understands the criteria on which client eligibility is based.

e. **Consultation** — Some psychiatrists have rendered an invaluable service to Vocational Rehabilitation by serving as counsultants and reviewing cases with counselors on a face-to-face basis.

f. **Other Services** — The psychiatrist should help educate the public about mental illness, and he may work part-time in the community mental health clinic or other mental health facilities.

2. Other Medical Services

An effort should be made to better familiarize physicians and counselors with each other's problems and objectives, for a strong working relationship between these two professionals is imperative if maximum rehabilitation is to be achieved.

a. **Examinations** — A general medical examination for every rehabilitation client is significant in that it may verify the existence of apparent or suspected disability and may also reveal some disability which has been heretofore unsuspected. Often, and especially with young people, this is the first opportunity for them to see a physician in general practice. The experience of the examination and their reaction to it may offer valuable counseling information. For some clients this examination may be one of their first contacts with a working person, i.e., a busy doctor. This is the beginning of a series of relationships which offer the client an opportunity to relate to people busily engaged in their work.

b. **Treatment** — The physician provides treatment, such as medication and surgery, as needed. He and the counselor may select appropriate "community resources, direction of care, the forces which motivate—personal, clinical, financial and others."[1] They often delegate responsibility to special services and resources—dentists, physical therapists, etc. When these services have been completed, the responsibility reverts back to the physician and counselor.

c. **Referrals** — The physician or dentist is often a referral source of rehabilitation cases, and this service is valuable if they understand the purposes and eligibility requirements of the agency.

3. Psychological Services

a. **Testing and Evaluation** — The major role of the psychologist is testing and evaluating, two of his traditional functions which are often essential in the rehabilitation process. Test results should be accompanied by a thorough, meaningful evaluation and recommendations for treatment.

b. **Therapy** — It may be necessary to develop a new role for the psychologist in regard to counseling and education. The person who is well trained in consulting psychology can often be helpful in counseling the mentally ill individual or members of his family. The psychologist may be especially useful in group work if trained in group dynamics.

c. **Education** — Psychologists in the community seem to adopt more of an educational approach as contrasted with the disease-treatment approach of the medical profession. Because of the psychologist's knowledge of developmental processes, social system analysis, and research, he is able to function as an educational and social critic of various institutions within the community. The role of the psychologist becomes increasingly more dynamic as the complex problems of individuals and of the community become major challenges to rehabilitation workers. In the future, the psychologist may be called upon more frequently than in the past to conduct group work in workshops, adjustment centers, and other similar settings.

C. OTHER SERVICES

1. Social Services

a. **Referrals** — The social worker or mental health worker should serve as an excellent source of referrals of persons who need Vocational Rehabilitation services, being in a unique position to identify such persons whether working under an agency or in a facility.

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[1] Gerald E. Cubelli, "The Physician and the Counselor," *Rehabilitation Record*, No. 2 (March-April, 1965), p. 17.

b. **Casework** — The scope of casework services largely depends on the capacity or position in which a social worker is operating. The social worker provides individual counseling, group counseling, family services, etc.; but the nature of each of these will depend on the situation. A social worker's responsibility may sometimes be limited to what can be done in an office setting, although it should extend to the client's home. During home visits, the social worker may counsel family members regarding relationship problems, budgeting, and management. Other functions of the social worker may include taking the client for a job interview, seeing that the client begins medical appointments, or providing other supportive services.

c. **Follow-Up** — Closely related to casework activities are the follow-up services frequently rendered by the social worker. Follow-up is particularly important when a mentally ill person has been released from an institution or treatment center, because often the social worker is the only person who remains in contact with the client. The social worker should provide transitional and continuing support, evaluate problems, and be aware of relapses in order to arrange further treatment or referral if necessary.

2. Marriage and Family Services

a. The Marriage Counselor

(1) **Selection** — Marriage counseling is such a new field that most states have not yet adopted legislation regarding the requirements for entering this profession. Therefore, a marriage counselor should be selected very carefully.

(2) **Functions** — The functions of the marriage counselor include individual, conjoint (couple), family, and group counseling; assisting with a variety of premarital, marital, personal, sexual, and family problems, and educating the public. The marriage counselor may be in private practice alone or with a physician or psychologist; or he may be affiliated with a college, a family service agency, or some other agency or clinic. Increasingly marriage counselors are included on the staff of large churches.

b. **Marriage and Family Life Education** — Marriage and family life education, when taught by a competent person, holds tremendous potential in the prevention of mental illness. An ideal community educational program in this area would provide appropriate education for every age and for all citizens, despite sex, marital status, cultural level, education, or socioeconomic status.

(1) **Family Life Education in the Public School Curriculum** Every school level should include family and marriage education as an integral part of its curriculum.

(a) Teacher — At the high school level such classes should be taught by an individual who has special training in this area. It might well be the homemaking or family relations teacher. She can utilize gynecologists, a marriage counselor, or other professional people in the community to teach subject areas in which her knowledge is weakest.

(b) Structure of Classes — These classes should include students of both sexes and should be geared to the age and maturity of class members. The classes should be small, preferably a group-counseling type of setting. It is suggested that students be required to take at least one of these courses during high school, and that it be a regular credit course but one without a letter grade.

(c) Course Content — A high school preparation-for-marriage course should include readings and discussions of topics such as: insight into one's behavior, values and how they influence behavior, personal hygiene and appearance, dating problems, physical affection, premarital sex, sex education, love versus infatuation, selection of a marriage partner, the appropriate time to marry, the premarital examination, the honeymoon, contraception, family budgeting, problems of early marriage, and how to deal with marital conflict.

(2) **Family Life Education for Adults** — Marriage courses for college students and adults in the community might follow adaptations of the topics mentioned. Frank, comprehensive classes on marriage are ususally enlightening to the emotionally disturbed person. He may gain assurance that his feelings and problems are "normal" and may benefit from new factual information.

(a) Sponsorship — Courses for adults in the community are usually planned by the Mental Health Association; they should be taught by a professional marriage counselor and/or other resource persons.

(b) Family Life Institutes — Family life institutes have been quite popular during the last several years. One or more well-trained marriage counselors are invited into a community for an entire week to conduct such an institute. They may speak to adolescent school groups during the morning, do individual counseling in the afternoon, and conduct adult classes in the evening. These institutes are usually sponsored jointly by the local school board and by a church or group of churches, although they are sometimes initiated by the Mental Health Association or some other community organization.

3. The Guidance Center

a. **Types of Guidance Centers** — There are several types of guidance centers, and they vary in the services offered and in their effectiveness. Some guidance centers are operated by private groups, while others are under the direction of a university and are used to train students. A few guidance centers are operated by religious associations.

b. **Services** — A guidance center offers outpatient clinical services, day care services, diagnostic services, consultation and education, individual and group therapy, individual and group counseling, clinical social work and family services, research, and training.

c. **Personnel** — The staff of a guidance center should include a psychologist, psychiatrist, social worker, a rehabilitation counselor, psychiatric nurse, psychiatric aide, and a recreational therapist. These personnel may be employed in the center full-time, part-time, or on a consultative basis.

4. The Clergy and Pastoral Counseling Centers

Numerous studies have indicated that persons who are disturbed are more likely to seek help from a minister or priest than from anyone else. Even persons who do not attend church regularly and who do not seem to be religious-oriented often go to a minister for counseling.

a. **Training in Counseling** — Due to the considerable amount of time that most clergymen spend in a counseling capacity, seminaries should be encouraged to emphasize counseling as an important aspect of the ministry and to provide courses and supervised experience in counseling. There is a great need for training in pastoral counseling in the community, and such training can be arranged in a number of ways. For instance, the local ministerial association might invite a competent marriage counselor and perhaps a psychiatrist, gynecologist, or psychologist to conduct training sessions for them. Several religious denominations employ a counselor to:

(1) Provide counseling services to residents of a given area.

(2) Provide educational services and counseling supervision to ministers of that denomination who are located in the area.

b. **Pastoral Counseling Center**

(1) **Availability** — Few pastoral counseling centers exist, but probably more of them can be expected in the future.

(2) **Functions** — These centers handle most or all of the counseling which would ordinarily be done within the cooperating churches. The counseling may be done by various ministers who work there at a scheduled time each week, or by a full-time person who is trained in pastoral counseling. The center may also be responsible for family life education programs for the cooperating churches and the community as a whole, and for training ministers in counseling. A special effort should be made to train ministers to recognize individuals with problems which they themselves cannot handle, and to make them aware of various community resources to which they may refer such persons.

c. **Churches** — The church itself seems to be a mental health resource. Despite the fact that churches often instill in individuals an unhealthy degree of guilt and self-condemnation, regular church attenders generally seem to be happier and more stable individuals.[1] Churches sometimes render excellent social and recreational services in addition to their spiritual emphasis.

5. Services for the Emotionally Disturbed Child

Services for children are inadequate due to long waiting lists, large case loads, lack of a sufficient number of suitable foster homes, and the difficulty and length of time involved in working with disturbed children. Preventive programs have been inadequate and practically non-existent because of lack of money and personnel. Many of the services and facilities required in treating the mentally ill child are simply modifications of treatment for adults.

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[1] Richard V. McCann, the Churches and Mental Health (Basic Books: In Preparation).

a. **Day Care Services** — Day hospitals and day care centers are probably used most frequently, because they allow the child to maintain daily contact with his parents.

b. **Residential Facilities** — Sometimes the home environment is a contributing factor to the child's maladjustment, and in such cases it may be best to partially or entirely separate him from his family. Hospitalization in a children's hospital or in the children's ward of a general hospital may be indicated. The child may be placed in a residential treatment center or a resident school, particularly if he is past the usual age to begin first-grade and yet is not allowed to attend a public school due to the severity of his disturbance.

c. **Foster Home Care** — Children are often placed in foster homes. This may be necessary because their parents have neglected them and do not care for them properly. However, it may be that the parents or other family members care but are unable to understand and fulfill the needs of the upset child. Putting him in another home gives him a new environment which may possibly meet his needs better. Such a placement is an extension of therapy. Foster parents know that the child will live with them temporarily and yet conceivably for quite some period of time. Foster homes should be screened carefully. Foster parents are usually paid slightly less than enough to meet the additional expenses of having another family member. The child may or may not be allowed to visit his parents or have them visit him. Foster home care, prenatal and well-baby clinics, and other special services pertaining to children are handled by public agencies.

d. **School Services** — Adjustment programs in public schools can be instrumental in helping disturbed children in a number of ways. Pre-schools and elementary schools increasingly cooperate with the Public Health Service in attempting to detect symptoms of mental illness and in eliminating conditions which are conducive to poor mental health. The mental health program in a school may include observation, testing, visiting the home to observe the environment and to talk with parents, and educating parents. Larger, wealthier school systems are able to employ psychologists, social workers, nurses, and specially-trained teachers in addition to the usual counselors, attendance officers, and visiting teachers. Many retarded and emotionally maladjusted children are enrolled in special education classes. Many of these programs need to be expanded by increasing services and providing more teachers so that classes may remain small.

e. **Training Schools** — Training schools for juvenile delinquents should provide more staff per child and be smaller than they presently are. A large number of new community training schools are needed so children will not have to be sent far away from their family and be entirely isolated from their community.

6. Geriatric Services

a. **Problems Faced by the Elderly** — Geriatrics is closely associated with mental illness. Due to medical advancements and the extended life expectancy, the number of elderly people in our society is increasing rapidly. There is a high rate of mental illness among this group; many suffer from cerebral arteriosclerosis, senile brain damage, and other types of mental illness. Many of our elderly citizens are deprived socially, emotionally, and physically. Many of the aged have no living relatives and a few are neglected by their relatives. The elderly are usually reluctant to accept from others the financial help, living accommodations, and assistance with daily living activities which they need, for fear of being a burden. At the time in life when they have the poorest health and most medical expenses, their income is lowest. At the time in life when they have the greatest amount of leisurely time, they usually have the least contact with other human beings. Therefore, they tend to be depressed and are very subject to mental illness because of both physical and psychological reasons.

b. **Special Services** — Within the last few years, a great deal of progress has been made in providing services for the elderly. For instance, MEDICARE and MEDICAID have come into existence. More families have offered to take an aged person in their home to live (foster home care for the aged), and group homes also have become more common. Larger cities have set up homemaking services whereby a worker checks with the aged, either in person or by phone, at scheduled times to see if all is well. A homemaker service includes a wide range of assistance and is adapted to the elderly person's needs. For instance, it may include delivering prepared meals to the aged's home three times a day, cleaning the house, or providing transportation to social activities. Homemaking services should be included as part of an ideal service program for elderly mentally ill individuals.

c. **Housing for the Aged** — A number of large apartment buildings or entire villages for the aged have been constructed. This type of housing arrangement provides excellent recreational and social activities and is an outstanding opportunity for the aged who can afford to live there. However, such facilities are usually commercial establishments and are expensive.

d. **Nursing Homes** — Nursing homes, which are often called "convalescent homes" or "homes for the aged," are also expensive; not only are they commercial, but they require additional staff due to the poor health of the majority of their residents. While these homes are designed for short-term care of individuals of all ages who need nursing care, in reality they seldom have patients besides the elderly, and many of their aged stay in the home the remainder of their lives whether or not they require nursing care.

(1) **Trend toward Nursing Homes** — There has been a tendency to send aged persons to a mental institution, often for the rest of their lives, when they become senile and difficult-to-manage. There seems to be a current trend to send them to nursing homes instead. The latter would appear to be a better alternative than the former, provided that the nursing home are good ones and there is a sufficient number of them. Adequate, attractive, well-operated nursing homes are essential for a community to provide ideal services for its aged who are mentally ill.

(2) **Quality of Nursing Homes** — A close examination of nursing homes reveals that presently few of them meet these criteria. Nursing homes are profit-making except in the case of those operated by religious groups. Because there are not nearly enough nursing homes, and because those which exist are over-crowded, state legislatures have been extremely reluctant to indirectly deter the establishment of such homes by requiring them to meet higher standards.

(3) **Encouraging a Healthful Atmosphere** — Nursing home operators should be encouraged to make their physical plant as cheerful and attractive as possible and to provide patients with private rooms in which they may keep a few of their favorite possessions. Civic and religious groups can do a great deal to improve the atmosphere of nursing homes by

visiting the elderly, presenting programs to them, and planning occasional recreational activities. This gives patients contact with the community outside the nursing home, and most nursing home managers are very appreciative of interest shown by community groups. Such contacts as these provide additional incentive for patients to get out of bed, eat in the dining room, go outdoors, and socialize with each other.

7. Court Adjudication and Related Areas

a. **Loss of Rights of the Mental Patient** — Upon commitment to a state hospital the mentally ill person loses his rights as a citizen, and these rights are not automatically restored when he is released for a trial visit. For instance, he is not allowed to possess a driver's license or to vote. He cannot have a bank account or write a check; and even though he can work and receive pay, he is not supposed to cash a check. These rights are almost essential if an individual is to obtain employment and to lead a reasonably normal life in the community. A person on trial visit may obtain the services of a lawyer to help him seek restoration of his civil rights before the end of his trial visit. Of course, he must pay the lawyer. After one year's trial visit, these rights are automatically restored. If a person is discharged, he must wait twenty days and then go to the county judge, who may restore his rights. The ex-patient may not be aware of the proper procedures and should consult a rehabilitation counselor, social worker, or some other person who works with the mentally ill for details on how to regain his civil rights.

b. **The Mentally Ill Public Offender** — Court adjudication is extremely important to the mentally ill public offender who has been discharged from a state hospital. Probation and parole services of courts are necessary in restoring the mentally ill offender to a socially acceptable way of life. However, communities frequently do not seem to realize the importance of these services; and, therefore, the services are often inadequate. Many probation and parole personnel are not provided with the materials, which they need in order to work efficiently.

c. **Juvenile Delinquency and Related Problems** — During the last several years, a wide variety of projects designed to combat juvenile delinquency have sprung up. This is commendable and other prevention-oriented projects are needed. Also, services for the person who is already a delinquent generally ought to be expanded. Some of the major services needed are small local correctional or training institutions for youth, foster home care, clinics and guidance programs for children and adolescents, and the family court. Obstetricians might cooperate with schools or civic groups to provide more adequate sex education, courses in prenatal care, and satisfactory arrangements for unwed mothers. While homes for unwed mothers are necessary due to lack of sufficient foster homes, it is sometimes preferable to place the unwed mother in a private home outside the community.

8. Services for the Alcoholic

"Since 1940 the number of persons identified as alcoholics has increased tremendously. The World Health Organization estimates that there are more than 4.5 million alcoholics in the United States."[1] Alcoholism is often complicated by the existence of other mental disturbances, and it is often found to co-exist with public offenses, marital problems, depression, brain damage, inability to maintain a job, and social and economic failure.

a. **Resources for the Alcoholic** — Many general practitioners, clinics, social agencies, and general hospitals do not accept alcoholics for treatment due to the low rate of success in treating them. With all the current advances in medical science, it is hoped that the medical profession will soon be able to contribute a great deal more to the rehabilitation of alcoholics. The facilities and programs which have been most successful in treating alcoholics have been day and night hospital programs, centers or clinics especially for alcoholics, vocational counseling and rehabilitation services, and follow-up care by Public Health nurses. Halfway houses, some of which are specifically for alcoholics and others which are for persons with any type of mental illness, have been effective. Various group work programs have helped many alcoholics, particularly when group counseling was available to the marriage partner or entire family as well as to the alcoholic himself. There is a need for additional alcoholic clinics in Florida. These clinics should include detoxification units in their service programs.

b. **Alcoholics Anonymous** — Alcoholics Anonymous has probably been more successful than any other single group in rehabilitating the alcoholic, and fortunately its services exist in fairly small communities as well as large ones. Alcoholics Anonymous is a fellowship of persons who have an honest desire to stop drinking and who share their experience and strength with others who come to them for help. Alcoholics Anonymous charges no fees and is associated with no agency, institution, or sect. Its limited expenses are taken care of by donations. Its members view alcoholism as an illness or "allergy" which cannot be cured but can be arrested by total day-by-day abstinence. Regular meetings are held in which members enjoy a sense of fellowship as they hear personal stories and interpretations from each other. Members strive to follow twelve steps which are centered around a deep feeling of humility and reliance on a Greater Power. Most members think of this Power as being God, although some have been helped by giving this term some other personal meaning. Alcoholics Anonymous members seek to arrest alcoholism through a spiritual awakening; and indeed, deep emotional experiences often seem to help alcoholics recover.

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[1] Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities, *Planning of Facilities for Mental Health Services*, (Washington, D.C., U.S. Department of Health, Education, and Welfare, January, 1961).

c. **Alcoholic Rehabilitation Program** — The Alcoholic Rehabilitation Program in Avon Park will accept referrals from throughout the state. This program provides an intensive inpatient program which includes detoxification, medical evaluation, psychological and social services, Vocational Rehabilitation services, occupational therapy, group therapy, family counseling, and research. There are five smaller treatment centers located in Jacksonville, Miami, Orlando, Pensacola, and Tampa, and other centers are currently being planned.

d. **Court Programs** — The court program in Miami is an excellent example of the types of services which can be rendered effectively to the alcoholic. This court program might well serve as a model for other cities.[1] It includes a large number of services and emphasizes the team approach.

(1) **Involvement** — The alcoholic becomes involved in the program when he is in jail and goes to court to be sentenced. The court has two appointed alcoholic rehabilitation officers who are members of Alcoholic Anonymous, and these officers screen cases and recommend to the judge persons whom they believe would benefit from serving their sentence in the alcoholic rehabilitation program.

(2) **Treatment** — The alcoholics selected may first go to

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[1] "City of Miami-DVR Alcoholic Program: How It's Working," *The Rehab Reporter*, 2, No. 2 (October-November, 1967), p. 4.

Avon Park Alcoholic Rehabilitation Center and then back to community programs, or they may start out under community training programs. Two halfway houses for alcoholics are provided through the cooperative services of the county welfare program, and every alcoholic spends some time in each of these houses. A month is usually spent in the first halfway house, which serves as an adjustment center. During this time, the alcoholic is involved in a workshop, intensive Alcoholic Anonymous activities, group work, resocialization, etc. Then he goes to the second halfway house for three to six months. This facility is a halfway house in its purest form; the resident is involved in vocational training or is employed, and he is more independent and is increasingly involved in community activities. His contact with Alcoholics Anonymous continues, but on a less intensive basis.

9. Services for the Addict

a. **Liberal Attitudes about Marijuana** — Marijuana can be easily grown and is readily available in most communities despite the illegality of its sale and use. Actually, marijuana is not habit-forming in that it produces only an emotional dependence; nor does it seem to generally cause any physical damage. For this reason, Americans have taken a rather liberal view of marijuana, which might partially explain the increasing number of drug addicts in our country. Marijuana is often used by the drug vendor to introduce other drugs which are habit-forming and more dangerous, such as heroin, opium, cocaine, and morphine.

b. **Dangers Involved in Use of Drugs** — Individuals who use these drugs eventually feel that they must have them. Because the drugs cannot be produced here and must be smuggled into the country, and because they are sometimes difficult to obtain, they are extremely expensive. The user's compulsion to use them may compel him to other illegal acts in order to secure enough money to purchase the drugs. Prolonged use of the drugs lead to sexual impotence for the male or perversions for the female, faulty memory, intense itching, dry mucous membrances, cardiac palpitation, fatigue, loss of coordination, anemia, lurid fantasies, tremors, paranoia, etc.[1]

c. **Limited Resources for Addicts** — According to statistics, drug abuse has been handled somewhat ineffectively by law enforcement officials. Professionals who might possibly be able to help the addict have conducted little major research dealing with treatment for the addict, and relatively few psychiatrists and other physicians have attempted to help the addict. Two or three hospitals for addicts exist in our country, and perhaps others will be established in the future. Careful supervision and security measures are necessary in treating addicts during the withdrawal period. Withdrawal is usually very gradual and is partial, although this is not always the case.

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[1] James A. Brussel, M.D., *The Layman's Guide to Psychiatry*, (New York: Barnes and Noble, Inc., 1961), p. 114-22.

d. **Halfway House for Addicts** — One of the more promising developments for addicts is exemplified by Daytop Lodge, a halfway house for addicts on Staten Island, New York. Its treatment program was begun largely on the basis of the addict's increased ability to resist drugs if he is subjected to regular drug detection tests. Firm justice is combined with warm concern, a very attractive physical setting, group therapy, seminars, lectures, and detection tests. Residents are expected to refrain from physical expressions of anger and to abstain from narcotics; therefore, a person with positive detection tests must make a public confession and suffer punishment such as verbal rejection of the halfway house "family," loss of his job assignment, and confinement to his room.[1] Residents must learn to be mature and responsible—to grow up emotionally, socially, culturally, sexually, vocationally, and educationally. Thus far, Daytop has been quite successful in rehabilitating addicts who were previously thought to be hopeless.[2]

e. **Education** — Drug addiction is an area in which many advancements are likely to be made soon due to the critical nature of the addiction situation at the present time. Preventive education is the best means of handling this ever-growing social problem. Educational programs can be conducted in schools, civic groups, and churches, by inviting physicians and law enforcement personnel to speak on drug addiction. A community educational program might also include distribution of printed materials, showing relevant educational movies, and utilization of television and other mass media.

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[1] Joseph A. Shelly and Alexander Bassin, "Daytop Lodge: Halfway House for Drug Addicts," *Federal Probation* (December, 1964).

[2] Daniel Casriel, M.D., and David Deitch, "New Success in Cure of Narcotic Addicts," *The Physician's Panorama* (October, 1966).

10. Services for the Sociopath

a. **Description** — Some alcoholics and drug addicts may be sociopaths, but many other people also are sociopaths. For instance, the sexual deviant, the public offender, and others who are unwilling to conform to society's rules may fall within this category. The classic sociopath is a person who has no regard for others except when he can use them to accomplish his own personal objectives. The sociopath seems to have no conscience, no sense of guilt.

b. **Need for Treatment** — The sociopath is an extremely difficult person with whom to work, and relatively little is known about him. However, professional people are researching this illness in an effort to learn how to treat it. Meanwhile, the number of sociopaths seems to be growing rapidly.

11. Public Agencies

A discussion of miscellaneous services which are available for the mentally ill in an ideal community would be incomplete without mentioning the role of various public agencies. These agencies provide a wide range of services, some of which overlap, that are beneficial to the mentally ill. These services must be carefully coordinated in order to achieve maximum effectiveness. Some of the state agencies which serve the mentally ill are the Division of Mental Health, State Board of Health, the Division of Youth Services, the Division of Corrections, the Department of Public Welfare, the Division of Child Training Schools, the Division of Vocational Rehabilitation, and the Florida Alcoholic Rehabilitation Program. Information on the specific roles and functions of these agencies can be obtained from the individual agency.

12. The Private Non-Profit-Voluntary Agency

The private non-profit-voluntary agency plays an important role and lends powerful influence in many communities. National, state and local offices offer public information, public education, referral, and research services. Local chapters exist in many areas and many of these local chapters offer various direct services to the mentally ill.

13. The Library Program and Cultural Events

Drama, music, reading, clubs, and other such activities are universal expressions of human emotions and means of meeting basic human needs. They may help one gain insight into personalities and to understand and appreciate others more. They may help people laugh or cry, enjoy life to a fuller degree, and better see the beauty around them. These are important aspects of mental health.

a. **The Library Program** — The library program and cultural events are important in both the prevention and the treatment of mental illness. Such activities as these should be varied so as to be of interest to all segments of the community's population.

(1) **The Value of Reading** — Reading broadens one's experiences and his outlook on life. Reading is the means of relaxation used most often by some adults. It educates, entertains, relaxes, and stimulates. While the library program is useful to every age group if it is well planned, it is perhaps most beneficial to children and adolescents during the summer months. Some young people eventually become juvenile delinquents partially as a result of boredom or having nothing to do with their leisure time. If they have learned to enjoy reading, they are not likely to be seriously bored.

(2) **The Scope of Services** — The library should extend to outlying rural areas, nursing homes, hospitals, and adjustment centers by means of a book mobile or other extension services. The library program should be centered around a wide variety of good books but should also include recordings of music and poetry, art displays, and other cultural opportunities.

b. **Cultural Events**

(1) **Value** — Carefully selected cultural events provide healthy ways of enjoying leisure time. They are a means of real pleasure and relaxation for those who appreciate them, and others can learn to appreciate them.

(2) **Sponsorship** — Cultural events in the community may be planned and sponsored by a number of groups—a committee organized for this specific purpose, civic clubs, schools, churches, drama or musical groups, etc.

(3) **Types of Cultural Events** — These events should vary from informal, unsophisticated entertainment such as "hoedowns" to "highbrow" events such as operas and ballets. The cultural events of a community might include children's drama or music, a community orchestra or choral group,

and "hometown variety shows," as well as bringing in outside professionals.

c. **Club and Organizations** — Civic clubs, social groups, and organizations are also important. They often enable an individual to identify with a group and achieve a healthy sense of belonging. In the isolation of our modern urban way of life, such groups as these serve to provide friendly contacts with others who share common interests and goals. Teen clubs, Scouts, 4-H clubs, and home demonstration clubs seem to have been particularly effective in contributing to better mental health.

D. SUMMARY

Many aspects of the community contribute to a broad range of services and activities which are geared not only toward treating mental illness, but toward the general improvement of mental health. The community "mental health climate" can go a long way in preventing mental illness and in helping restore those who are mentally ill.

CHAPTER V

PLACEMENT SERVICES FOR THE MENTALLY ILL

Doris W. Hewitt, Ph.D.

William F. Twomey

A. THE ROLE OF WORK IN THE REHABILITATION PROCESS

1. The Importance of Work

Encouraging the mentally ill person to develop new interests and skills or else to take new interest in old occupational skills is an early and important part of the rehabilitation process. The importance of work in social rehabilitation is unmistakable and has been recognized for a long time. Work helps relieve anxiety and tension, increase socialization, and fulfill certain instinctual drives.[1]

2. Job Adjustment

It was pointed out earlier that mental illness is largely a matter of maladjustment, and that this maladjustment is sometimes related to some component of the job situation. Therefore, it seems reasonable to assume that preparing the ill person for appropriate employment and helping him obtain a job and to adjust to it, will go a long way in meeting his needs and helping him adjust to life in general.

B. COMPONENTS OF THE JOB SITUATION

1. Interaction of Components

The needs and demands of the work task, the social situation, the physical environment, and the mores of the job interact with the needs, demands, and abilities of the worker. When this interaction is a reciprocally satisfactory one, a status of adjustment to the job situation has been achieved.

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[1] Arieti, *loc. cit.*

2. List of Components

Paul Lustig has described the job situation in terms of the following five components:[1]

a. **Mores** — The institutional mores of the job, or the rules and customs of working.

b. **Skills** — The work task or skill for which the worker receives pay, including the type of task and the quantity and quality of production.

c. **Relationships** — The social or the interpersonal situation includes relationships to one's superiors, peers, and subordinates. These relationships may be with males or females and with individuals or groups.

d. **Environment** — The physical environment—space, area, temperature, light, sound, equipment, machines, tools, etc.

e. **The Worker** — The worker's interests, motives, traits, and abilities.

3. The Placement Process

a. **Selection of Type of Job** — The professional person working with the emotionally disturbed person toward adequate job adjustment must first choose the type of job which would seem most appropriate. The five job components listed above should be given careful consideration in selecting the type of job. Would the disturbed person be sensitive to written and unwritten rules of the work setting, and would he be willing and able to abide by them? What skills does he possess or is he capable of learning? Could he perform a certain skill reasonably well and at an acceptable rate of production? Would he be able to get along satisfactorily with co-workers? Could he tolerate the working hours and working conditions? Would the job present a challenge to him in that it would interest him and he would have an opportunity for increased responsibility, raises, or a promotion?

b. **Modifying the Person** — The counselor must usually work with the client on certain modifications to make him (the client) better qualified for the job.

c. **Modifying the Job** — It may be necessary for the counselor to solicit help in modifying certain aspects of the job to suit the client better, if this is possible.

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[1] Paul Lustig, "Differential Use of the Work Situation," Paper presented at University of Wisconsin, 1965.

d. **Resources** — A number of resources exist to help the rehabilitation or placement counselor reach a decision regarding these points. General medical, psychiatric, and psychological reports will be very useful. It may be necessary to send the client to a work-oriented facility for more detailed information on his aptitudes, interests, and social skills as related to a work situation.

C. PREPARING THE CLIENT FOR EMPLOYMENT

1. Means of Preparing Client for Employment

The counselor may work alone in preparing the client for work, or he may send the client to a work-oriented facility for personal adjustment training. This will depend on the degree to which the client needs help, the rate at which he learns, and his level of motivation.

2. Counseling

The counselor can be effective in helping the client fill out applications and prepare a resume, helping him find job leads, and teaching him how to dress for an interview, how to conduct himself during the interview, what to expect on the job, and positive ways of reacting to given situations. While this type of counseling can be done on an individual basis, it might be equally effective if done on a group basis. In a group situation, group members criticize and react to each other in numerous ways so that the group is much more like real life than is individual counseling. The counselor may not have sufficient time to counsel each client individually on job-finding techniques. If group counseling is used, a wide range of materials and resources such as movies and pamphlets should be used, and local businessmen may be asked to speak.

3. Special Problems in Placing the Mentally Ill

An individual who has been mentally ill will usually need more careful, thorough preparation for employment than someone who is disabled in other ways. The employer, also, may need preparation for dealing with his prospective or new employee.

a. **To Tell or Not to Tell** — "To tell or not to tell" has long been a serious question of the mentally ill and of persons helping them to find a job. There has been a tendency in the past to conceal the client's mental illness history from a prospective employer. This concealment may possibly have been the best approach in the past, since the typical employer, as well as his employees, undoubtedly had many misconceptions and fears of the mentally ill. Although the public still harbors misconceptions and fears, much progress has been made in educating them to the truths of mental illness, and today there seems to be general agreement that it is usually preferable to be very honest and frank with a prospective employer. Effective counseling is important and both the counselor and client should be aware that existing laws or insurance considerations may obstruct employment of persons with a history of mental illness or continuing use of medications.

(1) **When the Client Finds His Own Job** — Ideally the client will find his own job after the counselor has instructed him in certain techniques. When this is the case, it is up to the client to decide whether to tell the employer about his illness, and what to tell him. The counselor can encourage the client to be honest and make suggestions as to what he might say and how it could be worded. In some cases the client might refer the employer to the counselor for information regarding his disability, but it is usually best for the client to learn to handle this problem for himself.

(2) **When the Counselor Finds the Client's Job** — Some mentally ill persons will be unable to find a job on their own and will have to rely heavily on the counselor for assistance. In such instances, the counselor himself will check out job leads. He will discuss the job situation and the strengths and weaknesses of the client at length with the employer. If he then feels that the job might be a suitable one for the client, and vice versa, he will make arrangements for the employer to interview the client—but only after giving the employer a candid summary in lay language.

(a) **The Counselor's Approach** — When the counselor talks with the prospective employer, he should take the client's file with him. He should explain any medical or psychological reports or tests which would be helpful in understanding the client's behavior, limitations, and capacities. The counselor should present this information from a very practical viewpoint, being careful to avoid irrelevant psychiatric history and diagnostic explanations or strange medical terminology. The employer will be most interested in how the person looks, how he acts, and whether he can perform the tasks required. Copies of medical-psychiatric information should not be released to employers without the written consent of the client as well as the individual physician, agency or institution responsible for initiating the medical information.

(b) **Reassuring the Employer** — The employer is likely to express anxiety about how the other workers might respond to the mentally ill person. The counselor should reassure him about this unless there is actually reason to think that co-workers would really dislike or fear the client. It would be consoling to many employers if the counselor assured the employer that he, the counselor, would assume the responsibility of telling the client if his job should not work out after a trial period.

(3) **What the Client Should Know** — The client should know that the counselor has talked with the employer about his illness, but the client should be encouraged not to bring up this subject often or to talk with co-workers at length about it. Also, if there is a good chance that the job will not work out or if it is on a trial basis, the client should be informed of this.

D. ON-THE-JOB-TRAINING

On-the-job training has been a useful device in offering a somewhat tender and individual approach to the work adjustment of the client. On-the-job training minimizes pressures and allows for growth and maturity. Also, there is the opportunity of beginning at the client's level and not the employer's. Through the cooperation of business, industry, and government agencies, work adjustment training programs for disabled individuals have been established. Often the work-oriented facility cannot meet the needs of all those who need work services. Therefore, it is necessary to develop work adjustment and on-the-job training programs for those who are hesitant in taking their path to the outside world. Eugen Bleuler has made this comment on work as a part of the total rehabilitation of the mental patient: "The supreme remedy which, in the majority of cases, still accomplishes very much and sometimes everything that can be desired, is training for work under conditions that are normal as possible."[1] This transitional work setting has value for many clients; and with the resulting increase in self-confidence, they can usually return to social and occupational self-sufficiency.

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[1] Eugen Bleuler, *Dementia Praecox or the Group of Schizophrenia*, Translated by A. A. Brill (Authorized English Edition, The McMillan Company, New York, 1924), p. 443.

E. TRIAL WORK EXPERIENCES

1. Value of Job Tryouts

Job sampling or job tryouts are useful in determining what skills a person possesses or could quickly learn, how well he can follow instructions, how rapidly he can work, and how well he accomplishes certain tasks. Job sampling is usually conducted as a service in work-oriented facilities.

2. Involving Local Businessmen

It is highly recommended that the interest and cooperation of community businessmen be solicited for the purpose of on-the-job sampling. A few communities have been very successful in achieving this type of program and found it much more effective than simulated job samples. In Everett, Washington, the disabled, particularly the mentally ill and mentally retarded, are given opportunities to work for two weeks in a variety of jobs under the businessmen who joined in this effort.[1] These work experiences revealed the types of tasks and situations most appropriate for each disabled person, provided a degree of training, showed which jobs interested him most, and served to point out special problems. Also, some of the job-sampling actually resulted in the employer's hiring some of the clients when the series of tryouts was completed.

F. SUMMARY

Successful employment is ordinarily a vital, essential part of the rehabilitation process, and this is particularly true of the mentally ill. Successful employment provides healthful independence and interpersonal relationships, thus spurring the individual on to a normal life and involvement in the community. It is important, however, that the disturbed person's job be carefully selected; that he be thoroughly prepared to handle the total job setting; and that the employer know what to expect from him.

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[1] Bert Worley, "Our Community Is Our Rehab-Center," *Rehabilitation Record* (November-December, 1967), pp. 33-36.

CHAPTER VI

THE TOTAL COMMUNITY MILIEU (TCM)

William F. Twomey

A. CONCEPT OF THE THERAPEUTIC COMMUNITY

Although the primary duty of the mental hospital is to treat a patient for the illness which caused him to go to the institution, professional personnel have increasingly realized that social rehabilitation is of great importance and can be accomplished by the development of a "therapeutic community" within the hospital. This concept has recently led to a much broader approach, that of the "therapeutic home community." This community is characterized by meaningful activities with sufficient diversification to permit a planned and purposeful program of rehabilitation for each individual. It includes all of the communty, i.e., the total community milieu (TCM).

B. A WHOLISTIC APPROACH TO MENTAL ILLNESS

Rehabilitation must involve the total community milieu because it is the total or whole person who is in need of rehabilitation. A wholistic or "whole person" approach to rehabilitation is essential if the rehabilitation process is to be most effective and if its effects are to be long-lasting rather than temporary and superficial.

1. Various Aspects of the Person

Man is a physical being, and his physical condition often determines how he feels and behaves. He is hindered if his physical needs are not met. On the other hand, man is a social, emotional, intellectual, and spiritual being. If he suffers in one of these areas, he is likely to suffer in the others. If he is mentally or emotionally disturbed, even the physical part of his existence is affected.

2. Treating the Whole Person

Man is so delicately balanced that the various aspects of his nature are interdependent, with no one existing in isolation. For this reason, no part of man is treated in isolation. If surgery is performed to improve the functioning of the body, the individual is being treated emotionally at the same time. In the act of counseling an upset person about a marriage problem, one is helping him physically. In helping a chronic alcoholic, a physician not only helps him abstain from alcohol but helps him adapt better nutritional habits and grow in self-esteem.

3. Role of the Community Milieu

Since mental illness can best be approached from a wholistic point of view, treatment must be viewed in this manner. Therapy may be any measure, mental or physical, that favorably influences the body or psyche. This being the case, there seems little doubt that the community is the ideal place for treatment and that in a very real sense, the community milieu is treatment.

C. IMPROVING THE THERAPEUTIC COMMUNITY

1. Initiating Improvement

There have been requests from several professional groups, including psychiatrists and psychologists, for a conceptional framework which integrates the community and the individual. Much better coordination of services and improved methods of educating the public are necessary before a community can make marked steps in this direction. However, once the steps are begun, there seems to be a tendency for them to gain impetus. When the general public within a community is thoroughly aware of the nature of mental illness, its prevalence, and the kinds of services needed, there will be a spontaneous reaction toward providing these services and meeting the need. Professional persons must do all they can to educate the public, provide the services needed, and cooperate with each other for maximum effectiveness.

2. The Job to be Done—And Now

Each community must identify its particular problems and search out solutions to them, and rehabilitation personnel must identify and search out the roles they ought to play. The solutions and roles are important, and the element of time is important.

In the words of an anonymous immortal bard, [1]

> There is a tide in the affairs of men
> Which, taken at the flood, leads on to fortune;
> Omitted, all the voyage of their life
> Is bound in shallows and in miseries.
> On such a full sea are we now afloat;
> And we must take the current when it serves,
> Or lose our ventures.

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[1] William J. Miller, "Community Coordination for Rehabilitation," *Journal of Rehabilitation* (September-October, 1958), 13 ff.

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REHABILITATION SERVICES FOR THE MENTALLY RETARDED

IDEAL SERVICES SERIES

VOLUME III

BY

JAMES FOSHEE, Ph.D.

U.S. DEPARTMENT OF HEALTH, EDUCATION
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STATE DEPARTMENT OF EDUCATION
Division of Vocational Rehabilitation
Rehabilitation Facilities Section

Tallahassee, Florida

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FOREWORD

The Ideal Services Series is an outgrowth of the Workshops and Rehabilitation Facilities Planning Project initiated by the Florida Division of Vocational Rehabilitation, State Department of Education, and the Florida Council for the Blind in 1966. The purpose of this planning project is to stimulate local professional persons and community leaders to plan for more adequate services for their disabled.

This guide is built around the concepts of the "therapeutic community" and "wholistic" approach to treating the individual. The disabled person, like other persons, can be influenced by the total community and all its services and aspects; and he reacts to the community as a whole person, not a segmented individual. Communities should consider their total needs and overall aims in planning for specific services and in making decisions regarding priorities.

The community should plan for all its citizens, including the disabled and specifically the mentally retarded. Much progress has been made in recent years in understanding retardation and in providing needed services to the retarded and their families. However, a great deal remains unknown about the origins of this condition, the best ways of dealing with it, and the types of services needed for the mentally retarded.

It is hoped that this volume will help make community leaders more aware of the needs of the mentally retarded, and that it will serve as a guide for them to plan for all the services needed for this disability group.

James Foshee, Ph.D., Director
Florida Division of Mental Retardation

ABOUT THE AUTHOR

Dr. James Foshee is Director of the Florida Division of Mental Retardation. Previous to his present position, he was a professor of Exceptional Child Education and Rehabilitation, Florida State University, and Director of two Sunland Training Centers in Florida. His area of exceptionality is residential and community facilities in the area of Mental Retardation. He earned his Bachelor's Degree from Jacksonville (Alabama) State College, his Master's Degree from the University of Alabama, and his Doctorate Degree from Peabody College. His field of study was Clinical Psychology and Special Education.

Dr. Foshee is a Fellow in the American Association of Mental Deficiency, a member of the Council of Exceptional Children, and American Psychological Association. He is the author of several publications relating primarily to activity disorders in children.

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ENDORSEMENTS

This publication, Rehabilitation Services for the **Mentally Retarded**, should prove to be a valuable tool for the use of individuals, groups and agencies working to improve services for the mentally retarded in Florida.

Through his authorship of this work, Dr. James Foshee has taken a significant step toward correcting a deficiency in available literature pertaining to mental retardation in our state.

This volume provides a needed look at services and facilities currently available to the retarded in Florida, and pointedly relates our current standing to future needs.

From foreword through final chapter, the contents of this publication clearly demonstrate that the vast majority of the mentally retarded can be useful, productive human beings if given proper care and training. The point is well-made that mental retardation can best be handled within the community, through active and concerned citizen participation along with the combined and cooperative efforts of the various professional disciplines and public and private agencies.

The Division of Vocational Rehabilitation of the State Department of Education, through its Rehabilitation Facilities Section, should be commended for publishing this work as Volume III of its IDEAL SERVICES SERIES.

Jack W. McAllister
Executive Director
Florida Association for
Retarded Children

CHAPTER I
INTRODUCTION

A. WHAT IS MENTAL RETARDATION?

Mental retardation is a condition, not a disease. It is an impairment of the intellect which prevents full development, thus slowing or limiting social adjustment, learning, comprehension, and reasoning. Mental retardation is often confused with mental illness, but the two conditions represent rather distinct disabilities: mental retardation includes intellectual deficits which are usually present at birth but may occur during early childhood or later developmental periods, while mental illness includes personality problems and behavioral disorders, especially those involving the emotions. Mental retardation is not necessarily accompanied by physical impairment or disordered emotions, although both may be present.

1. Classification of Mental Retardation

Two general approaches to the classification of the mentally retarded are frequently utilized. One emphasizes observable behavior rather than etiology; this approach uses measured intelligence and adaptive behavior as criteria for classification. The second approach emphasizes the etiological bases of the condition; this is, mental retardation is seen as a manifestation of some underlying process or biological condition.

2. Behavioral Classifications

There are varying degrees of behavioral deficit among the mentally retarded, and two general classification systems have been utilized to classify the level of deficit. One system focuses on measured intelligence and adaptive behavior, and the other focuses on the educational potential of the retarded individual.

a. Classification Emphasizing Measured Intelligence and Adaptive Behavior

(1) **Mild** -- The mildly retarded have IQ's from approximately fifty-two to sixty-seven. Development is slow, but they can learn; they can be trained for competitive employment and independent living.

(2) **Moderate** — The moderately retarded have IQ's ranging from approximately thirty-six to fifty-one. They can learn to work and to care for themselves but need to work and live in a sheltered environment.

(3) **Severe** -- The severely retarded are usually affected in speech and language and in physical development as well as mental growth. They cannot function completely independently from others but can learn to do a few things for themselves. Their IQ's are from about twenty up to thirty-five.

(4) **Profound** — The profoundly retarded suffer from gross impairment of speech, sensory, and physical development and are often physically handicapped. They need constant care for survival. Their IQ's are usually less than twenty.

b. **Classifications According to Learning Educational Ability**

(1) **Educable** -- The educable retarded are roughly the same as the "mildly retarded." Although these individuals cannot usually benefit adequately from regular school classes, with special help they can become literate, obtain competitive employment, and function independently. Approximately eighty-five per cent of all retardates are classified educable.

(2) **Trainable** — The trainable retarded are roughly the "moderately retarded." These persons usually cannot become literate and therefore cannot benefit much from programs for the educable retarded. However, in classes geared to their level they can learn motion skills, communication skills, self-care, and social skills. They may learn to perform many household tasks and be able to hold a job in a neighborhood or sheltered setting.

(3) **Dependent** -- About two per cent of the retarded are classified as "dependent" retarded. This category approximates the category of "profoundly retarded" and also includes some "severely retarded." The dependent retarded respond somewhat to training in habit formation but cannot assume responsibility for the activities of daily living.

3. **Causes of Mental Retardation (Etiology)**

In the majority of cases of mental retardation, science cannot yet pinpoint a specific cause despite the fact that remarkable advances have been made in this regard during the last few years. Mental retardation is often due to prenatal conditions or difficulties during birth, but it may also be the result of a deprived environment or the outcome of accidents or other causes of brain damage.

a. **Prenatal and Birth Conditions** — If a mother contracts German measles during pregnancy, her child is more likely to be mentally retarded. Other infections, too, may have this effect. Excessive X-ray exposure, premature birth, difficult birth, very prolonged labor, pelvic pressure, hemorrhaging, or respiration problems at the time of birth increase the likelihood of retardation. An increasing number of expectant mothers in our country receive no prenatal care.[1] Statistics indicate a direct correlation between how early in the pregnancy the mother sees a physician and the rate of prematurity — and thus, the likelihood of her child being retarded.[2]

b. **Deprivation** — Some children are born with normal intelligence but never have an opportunity for normal intellectual development, thus becoming retarded due to negligence and lack of stimulation. These children generally are exposed to little verbal communication and, therefore, they usually lack motivation to achieve or to develop their ways of thinking. Children need to hear many new words, see new places, and have an endless variety of experiences in order for their minds to develop properly.

c. **Brain Injury** — Brain injury can occur at any time in life as the result of a variety of causes such as accidents, brain tumors, certain infections, and faulty body chemistry reactions. An individual is usually considered mentally retarded if brain injury occurs before or during the seventeenth year of life.

B. GENERAL PRINCIPLES IN DEALING WITH THE MENTALLY RETARDED

There are several basic principles applicable to dealing with the mentally retarded which should serve as guides to working with these individuals on a personal basis as well as developing the kinds of programs and services which will best meet their needs.

1. Normal Environment

Mental retardation is often superimposed on itself; that is, because a child manifests some evidence of retardation, he is treated in a manner which causes greater retardation. The child should be allowed to live as normal a life as his condition possibly permits. Limitations within the home should be supplemented by community resources which expose the child to normal verbal communication, to other children and a variety of adults, and to new places and situations.

2. Behavior Modification

The retarded can usually be taught acceptable habits and basic character training by the use of proper techniques. They can also

President's Panel on Mental Retardation. *A Proposed Program for National Action to Combat Mental Retardation* (Washington, D. C.: U. S. Governmental Printing Office, 1962). pp. 51, 52.

[2] Ethel Collins Dunham. *Premature Infants*, A Manual for Physicians, (New York, Harper, 1955).

be taught to react to given situations in appropriate ways. Such behavior modification is most effective when it involves reinforcement by praise, attention, and tangible rewards. In this way even the severely retarded may learn toilet training, speech, and simple skills.

3. Basic Human Needs

The retarded possess the same basic needs as those of anyone else, and they are as subject as others (or perhaps even more so) to physical and emotional illnesses. They need a great deal of love and affection; they need self-confidence and respect; they need social contact with others. When they suffer from physical or emotional handicaps, they need help with their problems just as other people do, but they need help from a professional person who understands the problems of the mentally retarded.

C. PROVIDING SERVICES FOR THE MENTALLY RETARDED

1. Community Approach

In light of the foregoing principles, it is not difficult to understand why a community approach to services for the retarded is preferable to long-term institutional care. For some retarded individuals, residential training centers and hospitals are necessary, but these facilities must be considered as an extension of community programs. Every person needs a "place" of his own, and ideally this place is first his home and, more broadly, his community environment. His home and community are places with which he is familiar and in which he feels comfortable. It is generally preferable for the retarded person to remain in his home community if he can be served adequately there by programs which offer care, training, and assistance. Therefore, the community should assume responsibility for providing services for the retarded if these services can be reasonably developed on a local basis.

2. Ideal Services

The following chapters outline ideal services for the mentally retarded toward which communities should work. Area-wide, or regional, residential facilities are included in the discussion, but only insomuch as they are an extension of community services and are ideally within reasonable geographical proximity to the retarded person's home and family. It is recognized that no community can suddenly initiate all of the facilities and services suggested; but they may wish to establish priorities and begin to initiate programs based on their most urgent needs.

CHAPTER II
RESIDENTIAL FACILITIES FOR THE RETARDED

A. AREA-WIDE SUNLAND FACILITIES

The Division of Mental Retardation administers four state supported Sunland Centers (located in Gainesville, Ft. Myers, Marianna, and Miami) and two Sunland Hospitals (located in Orlando and Tallahassee). An additional facility, the Sunland Adult Center at Arcadia, is scheduled to begin operation on July 1, 1968.

1. Sunland Training Centers

a. **Purpose** — The purpose of Sunland Training Centers is to provide residential care and special training to ambulatory retarded children and adults.

b. **Adequacy** — The four Sunland Training Centers presently have a total capacity of approximately 4500 and a waiting list of about 1100. They provide services to all ages and to persons with varying levels of retardation. Additional centers are needed in order to reduce the waiting period for admission to a minimum and also to make residential services more accessible to any given community. However, all applicants cannot be accepted due to the fact that state residential programs are filled to capacity. As an alternative plan those awaiting state residential care may wish to obtain services through local, privately-owned facilities which exist in many communities.

c. **Cottage Plan** — Sunland Training Centers are based on the cottage plan. The ideal center should have a maximum of about fifteen residents per cottage.

d. **Services** — While state residential facilities offer primarily care and training, an effort is made to emphasize other services for certain residents. These services vary from one center to another, but generally they include special education, Vocational Rehabilitation counseling, and work services. Plans for the near future call for the special instructional program and work program to be upgraded as much as possible.

(1) **Vocational Services** — At least one Vocational Rehabilitation counselor will be assigned full-time to each center. The counselor will render personal and vocational counseling to residents and will direct the work services of the center. Work services will include a comprehensive work evaluation and training; and for the more capable residents, a program establishing jobs in nearby communities should be initiated.

(2) **Development Services** — In addition, for some resi-

dents programs will be established that will provide developmental experiences leading to good health habits and fundamental self-help skills. These programs will prepare the retarded person for possible future life in his home and community, where it will be essential for him to care for his own needs, share in home activities, partake of family life experiences, and perhaps participate in community activities.

e. **Personnel** — Each center, depending on its size, will need the following vocational rehabilitation personnel:

(1) Vocational Rehabilitation counselor (will supervise job placements outside the facility)

(2) A work evaluator (will be in charge of work sampling unit) for every six to ten persons served at any given time in the unit.

(3) An industrial therapist (will supervise residents assigned to jobs in the center itself)

(4) Secretarial help as needed

2. **Sunland Hospitals**

a. **Purpose** — The purpose of the two Sunland Hospitals is to care for the non-ambulatory retarded. These retardates generally have multi-disabilities and are either bedridden or in wheelchairs.

b. **Adequacy** — These hospitals have a combined capacity of approximately 1500, and at the present time this capacity is adequate. Because there are only two hospitals, there is a problem with regard to geographical distance from some areas in the state. Sufficiency of bed space may become a problem in the next few years as the number of more severely retarded adults who have remained at home during childhood increases.

c. **Services** — The services rendered by these hospitals are primarily medical and therapeutic care and attention, although an effort is made to expose residents to the outside world and to broaden their horizon of experiences. Training in the development of self-care skills is provided. As a whole the residents in these hospitals require a degree of attention and assistance which cannot be given practically in a home setting, and the hospitals aid the individual's family by assuming major responsibility for this care.

d. **Personnel** — The personnel in these hospitals consist of physicians, social workers, therapists, nurses, attendants, etc. No special Vocational Rehabilitation personnel seem advisable.

B. REGIONAL CENTERS

Florida is planning for a statewide network of community regional centers, and plans are now underway for two such centers. Eventually there should be a mental retardation center suitably located within each of the twelve regions of the state (as divided by the Division of Mental Retardation).

1. Purpose

The purpose of a regional center will be to coordinate services for the retarded within a given geographical area, to provide community-based residential facilities, to act as a fixed point of information and referral, to offer counseling to the parents of retarded children, and to consult with community leaders to help them develop plans for filling any gaps in the services which exist for the retarded.

2. Size and location

The regional centers will be conveniently located in the areas they are to serve, taking population concentrations and geographical area into consideration. Each center's size and scope of services will compliment existing community resources and, therefore, will vary from region to region. Each center's personnel and services may be located under one roof or may be in a number of separate five-to-six bedroom houses typical of a foster care setting for the retarded, depending upon the type of program offered.

3. Services

The center's services will vary according to the services available to the retarded through various other community sources. For instance, the center's program may include diagnostic and evaluation services unless these are already adequately provided by a clinic in the region. Its program may provide for an activity center or work services if these are not available through some already-existing source. In regard to services needed, the center may either provide these itself or may provide the consultation, stimulus, and direction to community leaders for developing local resources to provide the services needed.

4. Personnel

The personnel needed by the center will vary according to the services provided. Certain essential personnel such as a regional director and community consultants will be needed despite the services rendered, but additional staff may be added according to the general breadth of the program:

a. **Director** — This person will oversee all activities or services of the center. He will be skilled in administration and experienced in working with the retarded.

b. **Community Consultant** — The consultant will have the same basic qualifications as the director and should assist the director with administration, coordination, planning, and public relations. In addition he will be skilled in offering consultation on the development and augmentation of needed community programs and services for the retarded.

c. Secretarial Personnel

C. LONG-TERM HOSPITALS

Sunland residential programs, being tax-supported, have had to limit the number of residents served, based upon state legislative appropriations for the operation of these facilities. Other long-term hospitals, particularly mental hospitals, have had to absorb some of the ambulatory retarded for whom adequate care and services within the state residential programs for the retarded have not been available. If the mentally retarded are suffering from serious emotional disturbances, they should be placed in institutions for the mentally ill until such time as the emotional disturbance responds to treatment. If appropriately placed in a residential facility designed specifically to meet their needs, the retarded can profit to the extent that they may be able to function so as to be less of a burden and to be more capable of making a contribution to the society of which they are a part.

D. HALFWAY HOUSES

1. Purpose

A halfway house is a community-based residential facility equipped with supervisory staff who act as "parents." Such a facility is designed to enable the individual to adjust better to the abrupt transition between living in a hospital or training center setting and living in the community. The aim is to create a home-like environment nearly identical to that in the community and to bridge the gap between institutional and community living.

2. Single-Disability Approach

In general professional people working with the mentally retarded feel that it is best to establish halfway houses specifically for the retarded rather than putting them in houses designed for the mentally ill or for persons with physical handicaps. Their reasoning is that the qualifications of the staff, the in-house program, and length of stay of residents, and community relations might be far too varied for persons with different handicaps. The mentally retarded appear to adjust better in a home-like environment in which they relate to peers of their own intellectual level, especially when they are in a transitional period. If circumstances arise in which the retarded must share a halfway house with another handicapping condition, it has been found preferable for them to share with the physically disabled rather than the mentally ill.

3. Capacity

The ideal halfway house for mental retardates should have accommodations for eight to twelve residents.

4. Services

The services rendered by the halfway house are primarily residential. The halfway house is a partially sheltered living arrangement in which the resident can learn to get along with others and live relatively independently while he is prepared elsewhere for employment or begins a job. The residents are ideally of both sexes so that residents can learn to relate socially to both sexes in acceptable ways.

5. Administration and Operation

a. **Board of Directors** — Halfway houses are often operated by an incorporated group with a private board of directors. This is the policy-making body whose regulations determine:

(1) The selection of residents
(2) The criteria for discharge
(3) The methods of financial support
(4) Staffing needs
(5) Decisions regarding the in-house program

b. **Advisory Committee** — It is advisable to establish an advisory committee composed of key community leaders and professional people. This committee acts in an advisory capacity to the policy-making board and provides professional information and suggestions upon request of the board.

c. **House Parents** — House parents should preferably be a married couple, although they may be single men and women. They generally reside in the halfway house and are available to the residents at all times. House parents must be mature individuals capable of working closely with the retarded. They must also be able to work under professional supervision when this is necessary. "Relief" house parents should be employed in order to provide permanent house parents time off for rest and recreation.

E. HOSTELS

1. Purpose

The hostel often provides living facilities for the retarded who need even less supervision than that provided by halfway houses. An attempt is made to make the hostel indistinguishable from any ordinary residence such as a boarding house or apartment building. This goal is largely realized by enabling the residents to integrate into society as "social beings" and also as contributing members. Thus, every resident must be employed or have immediate plans for employment.

2. Services and Benefits

The major concrete services formally rendered are low-cost living accommodations and assistance from the director when stressful situations create social, emotional, or financial problems. However, the retarded residents of a hostel benefit in a number of other ways. Residents who are not yet employed may learn by planning and preparing meals and handling a budget under the director's supervision. There are a minimum of rules, and these rules are usually established by residents themselves. Residents benefit from the experiences of having a roommate and from voluntarily participating in occasional activities planned by the residents. Residents are usually single and relatively young, giving them much to share in common with each other.

3. Capacity and Personnel

The ideal capacity and personnel for a hostel varies according to the purpose of the hostel. Most hostels are designed for independent living, so that thirty or more residents might live in a facility with only a director in charge. Other hostels, while still designed to encourage independence on the part of the retarded, are geared for more dependent persons who are perhaps more handicapped. The hostel may therefore need a couple in charge rather than one person, in order to offer a greater amount of supervision. Both the degree of handicaps and the level of independent living toward which the facility is geared must be determined by its policy-making board.

F. SUMMARY

The facilities outlined here are those which provide residential services as their main function. They vary in regard to additional services, size, type of supervision, etc. Residential services are sometimes provided by other facilities such as schools for the retarded and workshops.

CHAPTER III
OTHER TYPES OF FACILITIES SERVING THE RETARDED

A. PRIVATE FACILITIES

There are numerous private and non-profit facilities in the state for the retarded. Some of these facilities are schools and/or day care programs, work-oriented programs, activity centers, camping and other recreation projects, and residential programs. Educational and training programs in these facilities are not required to meet any prescribed standards, and, therefore, their boards and administrators should be encouraged by community leaders to provide qualified personnel and close supervision of students. Moreover, a program appropriate for the needs of the retarded individuals being served should be provided.

1. Purpose

Private facilities provide programs and services which are similar to those provided by public facilities. School programs, residential programs, day care and training programs are provided in an effort to give retarded persons care and instruction appropriate to their intellectual and physical levels. Many of the programs provided by these facilities are limited, however, as a result of inadequate numbers of trained personnel and the absence of adequate space. Programs in these facilities vary widely with respect to size of classes, quality of instruction and chronological and mental ages of the individuals being served.

2. Persons Served

Persons admitted to programs provided by private and non-profit facilities may differ considerably in intellectual levels, chronological age and other characteristics. Frequently, but not always, parents seek the services of private facilities because, for a variety of reasons, public programs are not immediately available for their children. A list of private facilities in the state which includes descriptive data about each facility's program is published jointly and periodically by the Florida Association for Retarded Children and the Division of Mental Retardation.

3. Fees

Fees vary a great deal depending upon the type and amount of services being provided and upon the sources of support for the facility. Some facilities are able to provide services even though a child's parents are able to pay only a portion of the specified charge for the services.

4. Services

a. **Education and Training** — As previously stated, private facilities provide a wide range of services. If the facility is described as having a school for the educable and/or trainable retarded, the education and training service should be clearly defined. The program should be provided to all individuals served to the extent that they are capable of benefiting from such a program. For the educable retarded, instruction and experiences designed to accomplish the following should be provided:

(1) Intellectual development and academic proficiency in school subjects

(2) The development of emotional stability

(3) The development of good habits of health and hygiene

(4) The development of personal and social adequacy

(5) The development of attitudes, interests and skills leading to wholesome use of leisure time

(6) The development of attitudes, interests and skills leading to good citizenship and community responsibility

(7) Learning to work for the purpose of earning a living[1]

Instruction and experiences designed to accomplish the following for the trainable retarded should be provided:

(1) The development of self-help skills, safety, social and interpersonal relationships, and speech and language skills necessary to increase their potentials for more independent living.

(2) The development of emotional stability

(3) The development of good habits of health and personal hygiene

(4) The development of attitudes, interests and skills leading to a more wholesome use of leisure time

(5) The development of social attitudes and behavior patterns necessary for more adequate group living and participation

(6) The development of work habits, skills and tolerances for work for the purpose of personal satisfaction and usefulness in a sheltered environment[2]

b. Other Services — Other services provided by private facilities may encompass one or all of the following:

(1) Experiences in social living

(2) Vocational Rehabilitation services (for those of employable age)

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[1] American Association on Mental Deficiency. "Standards for State Residential Institutions for the Mentally Retarded." *American Journal of Mental Deficiency*, mimeograph supplement 68, 1964. p. 40.

[2] *Ibid.*, p. 43.

(3) A summer camp program
(4) Residential services
(5) Food services
(6) Recreational services
(7) Medical services
(8) Counseling for parents
(9) Social services
(10) Psychological services

5. **Personnel**

a. Basic Personnel — The personnel needed by a private facility for the retarded will vary according to the size of the facility, the programs provided, and the scope of its services. One or more of the following personnel may need to be employed either full-time or part-time:

(1) Director and/or business manager
(2) Resident physician
(3) Registered nurse
(4) Licensed practical nurse
(5) Psychologist
(6) Social worker
(7) Recreational therapist
(8) Dentist
(9) Chaplain
(10) Dietician
(11) Teachers
(12) Rehabilitation counselor
(13) Secretarial, clerical, and food services staff
(14) Additional Personnel -- Additional personnel such as attendants and houseparents will be needed if the school provides residential services.
(15) A variety of volunteer workers

B. SPECIAL EDUCATION IN THE PUBLIC SCHOOLS

Most retarded children should be provided special educational programs under the aegis of the public schools, and, in fact, of those retarded children receiving special educational programs in the state, most are receiving them under the aegis of the public schools. In general, classes are organized throughout the state for the "educables" and "trainables." Instruction and experiences designed to accomplish the same goals as outlined above for private schools are provided. For example, Florida has been providing instruction for the trainable retarded since 1964, and sixty-four of the sixty-seven counties have one or more classes for mentally retarded children in the 8-14 range.[1] Unfortunately, and until recently, the program was restricted because of severe financial limitations which resulted in curtailment of the program at the junior and senior high school levels. Moreover, the financial limitations resulted in programs being unavailable at all levels so that services were not provided for more than one half of those children.

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[1] The Florida Plan for Comprehensive Action to Combat Mental Retardation, State of Florida, 1964-65, p. 56.

While the shortage of programs and classes for the retarded in the public schools fail to meet the demand, two recent events make the picture brighter. One of these events concerns the future (Beginning in September, 1968) and is related to action of the Florida Legislature in a special session in 1968. The Legislature provided laws and funding for the mandatory establishment of classes for all handicapped children. Moreover, the intent of the Legislature was that the shortage of instructional programs for all handicapped children would be remedied within five years;[1] i.e., the mandatory law for the provision of classes for all handicapped would be fully implemented within five years.

The other event, the provision in 1963, for the Division of Vocational Rehabilitation to enter into cooperative agreements with local school systems to develop joint programs for the mentally retarded has already had a profound impact on seventeen county school systems.

Cooperative programs exist in one or more schools in each of these counties. These programs are serving more than six thousand clients.

1. **Objectives**

   The objectives of the cooperative school programs are:

   a. To provide Vocationally-oriented academic training to handicapped children in public schools in a manner adapted to their abilities and needs.

   b. To equip these students with basic social skills.

   c. To develop within them desirable attitudes toward work.

   d. To establish acceptable work habits.

   e. To prepare them for a suitable job or for further training for a suitable job.

2. **Curriculum**

   Academic skills are taught in the cooperative classes or programs and are applied in a practical, vocational manner to the students' lives. Work evaluation, personal adjustment training and occupational training are an integral part of the students' curriculum. Special centers such as horticulture and nurse's aide centers are established. Special students may be assigned to work stations in the school, such as the cafeteria, janitorial services, school office, sick room, library, etc., in order to gain skill and to learn how to hold a job. Also, on-the-job training situations in the community are utilized.

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[1] **Ch. 68-23, Senate Bill 86-X(68) p. 1, sec. 1, also, Ch. 68-18, Senate Bill 77-X(68), p. 2, sec. 1.**

3. **Classes**

The number of students per class may not exceed eighteen, as set by special education policy. The number of students in an ideal class would be fewer than eighteen but might vary according to the amount of special attention required by the students in a class at any given time.

4. **Classrooms**

It is important for classrooms to be attractive and of ample size. Each classroom is equipped with a homemaking center, a good grooming center, a living center, and with small tools.

5. **Development of Additional Cooperative Programs**

The special education program has the function of preparing handicapped children for future adult responsibility, and Vocational Rehabilitation has the function of assisting handicapped people to prepare for and adjust to employment. Neither has been able to fully meet its obligations to all handicapped youngsters because of limited staff and funds. The coordination of the school instructional program and the community service program has much to do in implementing the philosophy of each. Therefore, the development of additional cooperative programs should be given careful consideration. A collaborative program should develop after careful planning with regard given to such factors as the following:

a. **Information** — Both the state office of Special Education and the state office of Vocational Rehabilitation should provide information on their programs and what has been done in given areas to aid handicapped youth.

b. **Coordination** – The county coordinator of special education and the district director of Vocational Rehabilitation should work together in planning for a cooperative special education program.

c. **School Administration** – The school administration must understand the collaborative program and agree to provide certification of salaries within the legal framework and to develop a plan of operation if the cooperative programs are to function effectively.

d. **Curriculum** — The special education program should be based on a developmental curriculum with emphasis on community living and occupational preparation.

e. **Sequential Program** — If high school units are to be utilized as matching funds, there should be a sequential program from elementary through high school.

f. **Space** — There must be suitable classroom space which meets level III accreditation standards[1] for exceptional child programs. Adequate space must be available for rehabilitation counselors to work with students.

g. **Funds and Personnel** — Vocational Rehabilitation must have adequate funds available to finance a program and to assign an experienced counselor to the program. Funds earned by the program must be used for rehabilitation services to public school programs, with the specific program earning the funds having first priority.

h. **Agreement** — The directors or other designated staff from Exceptional Child Education and from the Division of Vocational Rehabilitation should visit and survey the facilities and determine whether criteria are met for an agreement. The county school system must be in compliance with Title VI, the Civil Rights Act of 1964, before an agreement is in order. The formal agreement will then be submitted through the county director of special education to the district director of Vocational Rehabilitation, who will channel the agreement to appropriate state and regional offices.

C. DAY CARE CENTERS

"The cost of care and training for a residential retarded child is approximately four times the cost for the child who attends a community day training center. Therefore, any extension of facilities that meets the training needs of the retarded and that allows the child to remain at home with his parents is of outstanding benefit to the child, his family, and the state economy.'[2] Day care centers are designed to bridge the gap between residential care, living at home and taking part in a day school or the special education program in a public school. The primary function of day care centers is to offer services to retarded children who are unable to meet admission requirements for enrollment in classes for the retarded because of their level of retardation, or because they exhibit physical or behavioral problems. Many trainable children are currently enrolled in day care programs, but this fact should change as more trainable programs are initiated by local school systems.

1. Existing Facilities

Most of the day care facilities currently in existence are operated by voluntary and parent organizations. Many day care units are partially supported by State Grant-in-Aid funds provided through the Division of Mental Retardation. The Florida Plan for serving the mentally retarded of Florida advocates that the education and training activities of the Sunland Training Centers be extended to establish programs for day students. Such programs would make it possible for some children to progress from residential status to day student status, and then to return home and enter special community programs; e.g., and special classes. Also, a child who has been unable to adjust to community special education classes or other community programs could be enrolled in the Sunland day training program.[1]

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[1] State Department of Education, *Accreditation Standards for Florida Schools.* (Tallahassee, Florida, 1963). p. VIII.

[2] Florida Interagency Committee on Mental Retardation Planning. *The Florida Plan for Comprehensive Action to Combat Mental Retardation* (Tallahassee, 1965), p. 77.

2. Services

The services offered by the day care center will vary according to the age and ability of the individuals being served. A program for elementary school-age children would obviously be quite different from one for adolescents.

a. Basic Services for Younger Children — A program designed for younger children should provide these services:

(1) Personal-Social skill training
(2) Food Services
(3) Recreation
(4) Transportation
(5) Health Services
(6) Parental Counseling

b. Services for Adolescents or Young Adults — In addition to the services listed above, work activities should be available for adolescents and young adults who are ready for them. These services must be part of a flexible program geared to a pace that students might perform successfully.

3. Personnel

a. Basic Personnel — (Some will be full-time or part-time depending on the size of the facility.)

(1) A director of the day care program
(2) Teachers
(3) Recreational therapist
(4) Social worker
(5) Dietitian and other food services staff

D. DIAGNOSTIC AND EVALUATION CLINICS

The majority of the mentally retarded are not "discovered" or brought to anyone's attention until they begin grade school. Diagnostic and evaluation clinic programs should be established to detect mental retardation at a much earlier age so that special attention and treatment can be given the child during the preschool years, increasing his chances of living a relatively normal, productive life in the community.

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[1] *Ibid.*

1. **Types of Clinics**

   Florida has no organized plans or policies regarding the establishment of diagnostic and evaluation clinics specifically for evaluating the retarded, although there are a few such clinics in the state. Detailed suggestions for establishing diagnostic programs which would be effective in casefinding and initiating work with the retarded and their families early in life should be developed. These clinics might be stationery ones in cities, located in areas where a high incidence of retardation is likely to occur. In smaller towns and rural areas the clinics might be mobile units which go to each location every month or every six months. The use of mass media would be extremely important in informing the public about the clinics so that they might operate effectively.

2. **Services**

   These clinics should render psychological and developmental diagnoses and evaluations, particularly to preschool-age children, and make referrals to available resources for therapy, special instruction, and counseling for parents. Clinic personnel themselves might provide limited counseling for parents of retarded children.

3. **Personnel**

   A diagnostic and evaluation clinic, whether in a stationery setting or mobile, calls for a multidisciplinary approach in order to perform comprehensive diagnoses. A basic team is essential, even if it consists of workers who devote only a part of their time to the clinic. The following basic team and consultants have been recommended:

   a. **Basic Team**
      (1) Pediatrician or pediatric neurologist
      (2) Clinical psychologist
      (3) Clinical social worker
      (4) Public health nurse
      (5) Clerical aides

   b. **Consultants**
      (1) Neurologist
      (2) Psychiatrist
      (3) Orthopedic specialist
      (4) Ophthalmologist
      (5) Radiologist
      (6) Geneticist
      (7) Obstetrician
      (8) Special educator

(9) Nutritionist
(10) Audiologist
(11) Speech therapist
(12) Rehabilitation counselor
(13) Physical therapist
(14) Occupational therapist.[1]

E. ACTIVITY CENTERS

1. Purpose

The purpose of the activity center is to effect behavior modification for persons who are not able to work in a productive setting. Clients in the activity center may learn hobbies and engage in very simple contract projects but are not generally under pressure to produce at any given rate. In cases in which behavior is improved sufficiently, the client may progress from the activity center to employment in a workshop.

2. Availability

Only a few activity centers exist in Florida. Those which do exist are usually free standing and are not a part of a rehabilitation center or a workshop.

3. Services

An activity center's services may vary a great deal, including only one or up to a large number of the many services which seem to modify behavior. Services may be social, vocational, recreational, etc.

4. Personnel

The center must have a full-time director and personal adjustment teacher. Other personnel will vary according to the specific services offered. If contracts are procured, personnel will be needed to handle the procurement. Frequently clients in activity centers are paid a small salary, and if this is the case, additional secretarial or clerical help may be needed to keep necessary records.

F. WORK-ORIENTED FACILITIES

Work-oriented facilities play a very important role in the habilitation of the mentally retarded. The functions of a work-oriented facility are to provide vocational services to the disabled to prepare them for competitive employment, and to serve as a place of employment for persons not capable of competitive employment. The services of personnel in a work-oriented facility will be discussed in detail in Chapter V.

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[1] *Ibid.*, p. 36.

CHAPTER IV
OTHER COMMUNITY SERVICES

A. INTRODUCTION

1. Responsibility of the Community

Whatever services are needed by the retarded should be available whenever they are needed. Although all of the services required by the retarded may not be available in every community, the community should at least have access to all the services needed. Also, the community ought to assume responsibility for continuity of services. The local Association for Retarded Children and Adults, the Regional Coordinator of the Division of Mental Retardation, the local coordinator of special education, the local rehabilitation counselor, and other groups or individuals may assist retardates and their families by helping them locate needed services and by encouraging community leaders in identifying and filling gaps in services.

2. Purpose of This Chapter

Some of the more important services for the retarded other than residential accommodations and rehabilitation facilities are discussed in this chapter. These services are generally available to all the citizens of the community, although in some instances segments of the regular program must be modified to be of greatest benefit to the retarded individual. In each case an effort has been made to specifically identify the role of the service mentioned in regard to habilitating or rehabilitating the mentally retarded.

B. PSYCHOLOGICAL SERVICES

Psychologists and psychometrists have a vital part in providing adequate screening and evaluation services for the mentally retarded. Increasingly they are also evolving new training methodologies. Psychologists are usually accessible in cities and areas with a university, but are often difficult to locate in small towns and rural areas. Vocational Rehabilitation personnel work with psychologists through three major channels in serving the retarded.

1. Regular Personnel

Psychologists may function as full-time or part-time employees or may work on a consultation basis for Special Education units in public school, in private schools for the retarded, and for work-oriented facilities and other rehabilitation facilities which serve retarded individuals.

2. Private Practice

The Division of Vocational Rehabilitation purchases testing and evaluation services from psychologists who are in private practice in the community or who are affiliated with institutions of higher education.

3. Referral

Psychologists serve as a source of referrals to the Vocational Rehabilitation agency. This is a valuable service when the psychologists are well-informed about the objectives, policies, services, and requirements for eligibility for services of the agency.

C. MEDICAL, OTHER PROFESSIONAL, AND HOSPITAL SERVICES

1. Obstetrician

The obstetrician has an extremely important part in the prevention of mental retardation by providing competent prenatal care and guidance for the expectant mother and by competent delivery of the baby. Although his work is generally done on an individual basis, he may conduct prenatal group counseling or supervise nurses and social workers in conducting such groups. The obstetrician should be careful to mention to every expectant mother certain precautions. When appropriate, genetic counseling should be made available.

2. Pediatrician and Neurologist

The pediatrician is probably in a better position than any other professional person to identify mental retardation at an early age. The pediatrician should be thoroughly aware of the numerous types of possible retardation and be alert to them. When he sees them, he should make appropriate referrals for complete diagnosis and should discuss the situation with the parents. The neurologist is important in diagnosing mental retardation, identifying its etiology, and making recommendations as to whether the retarded individual might benefit from physical or medical treatment of any type.

3. Other Medical and Professional Persons

Other physicians serve the retarded in much the same way they serve any person — by providing evaluations, treatment, and consultation for acute illnesses, emotional disturbances, surgery, or other conditions. They can help in the prevention of retardation using appropriate vaccines and diagnostic tests and by avoiding, when feasible, the use of drugs and X-rays for young women, particularly during the early months of pregnancy. Also, they are excellent sources of referrals to the Division of Vocational Rehabilitation. Prosthetists, audiologists, speech pathologists, ophthalmologists, physical therapists, and others also serve the retarded in a manner similar to the way they serve other people. However, more severe mental retardation is frequently accompanied by physical limitations, speech and hearing impairments, and other multi-handicaps which require special attention from professional persons. Nurses are able to assist retarded individuals in a number of ways. The more profoundly retarded need continuous nursing care, while the more mildly retarded and their families frequently need instruction regarding nutrition, personal habits, etc. The Public Health nurse often visits the homes of the retarded to offer instruction and assistance as needed.

4. **Hospitals**

   a. **In-Patient Services** — Hospitals can contribute a great deal to the prevention of retardation by having the best possible facilities, equipment, and personnel for providing prenatal, delivery, and postpartum services. The hospital staff should see that newborn babies are given appropriate laboratory tests, e.g., the "PKU" Test, and that they are cared for and observed carefully by experienced persons

   b. **Out-Patient Services** — Hospitals should cooperate with obstetricians, pediatricians, Public Health nurses, and others in sponsoring regular prenatal clinics, prenatal group instruction, and well-baby clinics.

   c. **Personnel Training** — There is a constant need for medical and other professional persons to obtain further training in their fields and to keep abreast of recent knowledge. Hospitals can always be of service by providing training for aides and other non-professional personnel. This type of training is particularly helpful when planned for persons working in a specific ward with persons who have specific illnesses, or for persons working in the nursery.

D. SOCIAL SERVICES

A broad variety of social services may be of benefit to the retarded person and to his family. These services range from those provided by social workers employed by service agencies to the assistance provided by community adult and teenage volunteers. Some of these social services are discussed later in the chapter.

E. EDUCATIONAL SERVICES

1. Preschool Programs

A well-operated nursery, nursery school, or kindergarten with a balanced curriculum and adequate staff provides new and stimulating experiences which may be invaluable to a retarded child. Preschool programs are particularly valuable to children who are retarded due to cultural deprivation in that the new experiences afforded the child motivate him to learn and to broaden his horizons, thus increasing his capacity to learn. Some nursery schools, kindergartens, and child care centers (which usually provide services for a wider age range) are planned specifically for handicapped children. In some cases the facilities exist primarily for average children but accept a limited number of handicapped children. Recently an increasing number of kindergartens and child care centers have been developed for the culturally deprived, and as the proposed changes in Welfare programs throughout the nation are implemented, the number of such schools will grow rapidly. Many children will probably be able to perform acceptably in regular classes who could not have done so without the benefit of attending a preschool program.

2. Remedial Education Services

Tutoring services, adult education classes, and remedial reading programs such as those provided by some universities may help slow learners or the mildly retarded to continue progressing in the development of communication skills.

F. SERVICES RELATED TO THE CHURCH AND RELIGION

The church and clergy are able to serve the mentally retarded and their families in several rather unique ways. It has been suggested that the spiritual aspect of life is more meaningful to retarded individuals than to average persons and that this fact results in the majority of retarded persons being exceptionally responsive to religious guidance.

1. Special Classes and Activities

If the size of the church allows this, the church may have special classes for retarded children and adults. Such classes might be conducted during Sunday School only, or they might continue during worship services or even be scheduled at other times. Today many churches operate nursery schools and kindergartens, and they may well incorporate retarded children into these programs. An increasing number of churches are offering their facilities (classrooms, playgrounds, etc.) for use as day schools or other community programs for the retarded.

2. Counseling

The pastor and other church leaders may be sources of encouragement and guidance by showing special interest in the retarded and their families and by counseling them as opportunities present themselves. Often the parents of a retarded child simply need an understanding person to listen to them as they ventilate their fears and problems. The clergy or the child's church teacher can be of great help to parents in times of the crises which arise when rearing a retarded child.

3. Referral

Churches are sometimes the first institution to have continued contact with retarded children. The church is likely to deal with these children at a very young age, and also it may have regular contact with older children and adults who are retarded and in need of special services but who are not aware that these services are available. The professional staff and other church leaders may render a helpful service by referring the retarded to diagnostic and screening clinics, centers or schools for the retarded, other facilities, or the Division of Mental Retardation or Division of Vocational Rehabilitation.

4. Publications

Some religious denominations have their own literature, personnel and printing equipment. They are in a unique position to prepare publications which will be informing and encouraging to the families of retarded individuals.

G. RECREATIONAL SERVICES

The more retarded individual is often unable to participate in the recreational activities of normal people, which may result in his tending to become shy and withdrawn and being unable to relate well to other people. Recreational activities are very important to the retarded person in that they help him learn to enjoy and get along with others, thus making him more pleasant to be around and more capable in his employment. Recreational activities provide a means of success, accomplishment, and constructive use of leisure time. Any individual may become a social problem if he is not taught to use his leisure time properly. The types of recreation in which a retarded person can participate depends on the training, degree of retardation, and physical condition of the individual.

1. Special Programs

Mildly retarded persons can usually take part in regular recreational programs; however, the moderately and severely retarded, in addition to their lower intelligence are often limited physically, therefore needing modified or special recreational programs. The directors of community recreational programs should see that recreational opportunities are available to all persons in the community. If special recreational services cannot be provided regularly, then they should be planned on some scheduled basis. The retarded can usually participate in any recreational activity as long as adequate supervision is provided. They enjoy scouting, swimming, sports, clubs, hobbies, dancing, etc.

2. Camps for the Retarded

For years the National Association for Retarded Children has encouraged the development of camping programs for retarded children, and a few of these programs exist in Florida. The Sunland Training Centers have provided camps for their residents for a number of years, and the Florida Association for Retarded Children has cooperated with the Easter Seal Society in providing a camp project for the past few summers; but few other camps are available, and those which do exist, if they accept the retarded, charge rather high fees. Community recreational leaders should be encouraged to develop camping programs for the retarded, and owners of private camps should be encouraged to reserve a portion of each summer in order to provide camping opportunities for the retarded. Day camps for retarded children are an excellent recreational activity.

H. FAMILY COUNSELING SERVICES

The presence of a retarded person in the home may result in more crises and continuing problems than a family would have otherwise. Therefore, family counseling services take on added meaning for such a family. Family counseling has long been provided by the Department of Public Welfare, and increasingly it is available through other public agencies and through community Family Service Agencies. Family counseling may be geared toward any number of goals such as improving parent-child relationships, achieving more stable and sound financial management practices, handling time and other resources more effectively, etc.

I. HOMEMAKER SERVICES

Many retarded adults who are able to live alone are not entirely independent. They may appear to function well and yet may be lacking in some of the most basic household and personal skills. For example, they may need assistance in housekeeping, preparing meals, shopping, and getting to work. Homemaker service programs are designed to render such services as these. The type, frequency, and scope of services vary from one person to another, depending on the skills and capabilities of the individual. Up to the present time, homemaker services in Florida have largely been limited to the child care program sponsored by the Department of Public Welfare, whereby homemaker service personnel care for children in their homes when their parents are temporarily unable to care for them.

J. FOSTER HOME CARE

The Department of Public Welfare currently provides for foster home care for more than 3000 children, including some mentally retarded children. Through this program children who cannot remain with their parents or relatives are placed in homes in which the parents seem suited to meet the child's needs in a warm, understanding manner. Both the child and the foster parents are aware that this living arrangement is temporary and can be terminated if it is unsatisfactory or if there is no longer a need for it. Foster parents are paid a modest amount each month to help meet the expenses they incur as a result of keeping the child. Qualified foster parents, and particularly qualified ones who would want to keep a retarded child, are limited in number. Also, the funds and staff needed to administer this program are limited.

K. PROTECTIVE SERVICES

Special care and protection, or guardianship, may be needed by a retarded child or adult whose parents cannot provide adequate care at home, or who outlives his parents. Protective services may be much like homemaker services, but involve more personal initiative and concern in that the services are provided by a volunteer who feels a deep interest in the retarded individual. Protective services are similar to foster home care in some instances, but involve the aspect of guardianship. This is an area which is badly in need of legal clarification in the state.

L. HOME TRAINING PROGRAMS

All areas, even rural ones, should ideally have some type of home visitation program whereby professional workers (usually Public Health nurses) visit the homes of retarded children periodically. Such programs are often sponsored by Local Associations for Retarded Children, and sometimes volunteer workers are also utilized. The persons who visit the homes should be prepared to listen to parents with empathy; to help parents better understand the levels of development; and to teach parents improved methods of coping with toilet training, self-feeding, educational play and other experiences, and the development of speech and motor skills.

M. OTHER SERVICES PERTAINING TO MENTAL RETARDATION

Professional persons and others who are concerned with mental retardation can do a great deal to assist with the problems of the mentally retarded. In addition to working directly with the retarded, they may help in three ways:

1. Educating the Public

They may help by doing all they can to inform the general public about mental retardation -- what it is, what causes it, what can be done about it. A well-informed public would result in more concern about meeting the needs of the retarded, thus bringing about more adequate services of all types and much broader employment opportunities for the retarded. The public can be educated through the use of films, television, and other mass media as well as through personal contacts.

2. Training Personnel to Work with the Retarded

There is a constant need for all types of personnel who are trained in working with the mentally retarded. Colleges and universities should be encouraged to offer courses in this area and to plan special workshops for training persons to work with the retarded more effectively. Hospitals, agencies, and other community groups can develop non-credit training programs of this type. Universities should provide models of ideal school programs, including preschool programs and programs for the trainable. They might employ high school and college students to work in such ideal programs on a part-time or summer basis, as a means of interesting them in this type of work.

3. Research

Institutions of higher learning and qualified persons and agencies should be encouraged to conduct scientific research related to genetics, the causes of retardation and means of preventing it, cultural effects on retardation, etc. Also, they should be encouraged to disseminate and put to use any significant findings.

CHAPTER V
VOCATIONAL SERVICES

A. THE ROLE OF WORK FOR THE RETARDED INDIVIDUAL

Few aspects of life are more important to an individual than work. Work helps one become more independent emotionally and financially, which leads to increased confidence, self-esteem, pride, and responsibility. Not only does the retarded person and his family benefit from his employment, but society as a whole benefits from it. When the retarded individual is working, he has become as asset rather than a liability to the national economy. Also, he is occupied so that he is less likely to become a social problem. Therefore, work takes on added importance for the retarded person.

B. PREPARING THE RETARDED FOR EMPLOYMENT

1. Range of Services

It has been estimated that at least eighty-five per cent of the retarded could support themselves to some degree if adequate vocational services were available.[1] Vocational needs consist of more than a need for training. A wide range of services is involved, including behavior modification and extending to placement and follow-up services. Vocational services include preparing an individual for a job emotionally, psychologically, and socially as well as providing him with appropriate knowledge and adequate skills.

2. Special Considerations

Since retarded persons are generally slow in developing new habits and attitudes and in grasping new concepts and skills, several factors must be taken into consideration in preparing a retarded person for work.

a. **Time and Repetition** — The retarded individual requires more time and repetition than the average person does in order to absorb and retain a given amount of material.

b. **Encouragement** — The retarded person may have experienced numerous failures in the past which may result in his tending to give up too readily. Therefore, he may need a great deal of encouragement and praise. Persons working with him should be patient and not easily discouraged.

c. **Basic Assumptions** — The teacher or employee should be careful to avoid assuming that the retarded individual already knows about certain regulations and other matters which persons of normal intelligence might already know.

d. **Presentation of Concepts** — New concepts should be presented in as simple a form as possible and gradually, one at a time.

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[1] The National Association for Retarded Children. *How To Bring New Hope To The Mentally Retarded*, (pamphlet).

e. **Goals** — The retarded individual may tend to harbor unrealistic goals and to stubbornly reject more realistic ones. This calls for considerable counseling and guidance on the part of the rehabilitation counselor, for it would be folly to prepare a client for a vocation in which he would face obvious and insurmountable barriers.

C. TYPES OF VOCATIONAL SERVICES NEEDED BY THE RETARDED

1. Vocational Counseling

a. **Purpose** — Vocational counseling begins with the counselor getting to know the retarded person and appraising his assets and liabilities. In some cases the counselor may work with an individual for a short period of time, guiding him toward immediate gainful employment. Other cases may be prolonged over a period of months or even years during which time the retarded person receives various services which help prepare him for job placement. The primary objective of vocational counseling is to develop a vocational plan for the person and to guide him as he proceeds with this plan, giving help as it is needed. The retarded person is encouraged to acknowledge his assets and weaknesses and to work toward improvement.

b. **Personnel** — Vocational counseling is usually rendered by the rehabilitation counselor, although it may be offered to some degree by the personal adjustment teacher, school guidance counselors, and others.

c. **Group Counseling** — Group vocational counseling is an effective tool but should be used as a supplement, not a substitute, for individual counseling.

2. Work Evaluation

a. **Purpose** — The purpose of a work evaluation is to make a diagnosis and to give specific recommendations regarding vocational preparation for an individual. The diagnosis and recommendations are based on the work evaluator's observations of the client and how he seems to function in a variety of situations. Such factors as the following are considered:

(1) The client's motivation

(2) The client's disability and resulting problems and limitations

(3) Personality factors, either positive or negative, which would affect the client's employment

(4) Personal habits such as dress, cleanliness, and courtesy

(5) Work habits such as punctuality and dependability

(6) Emotional factors

(7) The influence of the client's family and environment upon his chances of successful employment

(8) Previous education, training, and experience

(9) The client's needs and goals

(10) Work attitudes and values

(11) Any other major obstacles to the client's successful employment

b. **Setting** — The situations in which the work evaluator observes the client are usually structured inside a facility, although the work situation may sometimes be located in the community. The client is asked to perform numerous tasks of varying levels of difficulty. His reactions to anger, praise, close supervision, little supervision, and working alone are observed carefully.

c. **Personnel and Client Load** — A work evaluator should have special training or experience in the area of work evaluation. The work evaluator must interact closely with the individuals being evaluated, and therefore he should have a client load of no more than ten persons at any given time. Work evaluation units usually serve persons with all types of disabilities, and the caseload maximum of ten is based on the assumption that the clients will have a variety of disabilities including mental retardation. If the entire caseload should consist of mentally retarded persons, the evaluator should work with fewer than ten people. A typical work evaluator might complete approximately sixty work evaluations per year; an adequate evaluation would range from less than a week up to three months or more, with an average of about two months.

3. **Personal Adjustment Training**

a. **Purpose** — The goal of personal adjustment training is to modify behavior, appearance, or attitudes to make the client more acceptable for employment. Personal adjustment training should "endeavor to develop or strengthen rather fundamental qualities which ordinarily are taken for granted in job adjustment. The retarded group is peculiarly lacking in a readiness to assume work responsibilities for reasons other than job skills per se. Job readiness requires the development of work motivation, proper work habits, the practice of regularity of attendance and acceptable social relationships with others. This service is of value particularly to persons with no previous work experience and who do not understand the overall demands of work."[1]

b. Setting — An individual in personal adjustment training has usually completed a work evaluation in which the work evaluator recommended personal adjustment training and developed a prescription for the personal adjustment teacher's guidance. Together the work evaluator and the teacher should develop a prescription which specifies the client's assets, liabilities, needs, and a plan for a series of experiences which will improve the individual's overall personal adjustment. The teacher should have available a wide selection of learning situations or settings from which a client might be expected to grow in predictable ways. These learning situations are not limited to the facility, but extend out into the community. Personal adjustment training should continue until the individual is judged ready for employment or until he is no longer making progress. When he is ready for employment, he may go directly to a job or may receive training and further vocational counseling before accepting a job.

c. Personnel and Client-Load — A personal adjustment teacher should have great insight and understanding and should have special training in this type of work. Since the teacher does not deal constantly with all the clients under him, but may send them out for other experiences (interviews, work experiences, etc.), he can manage up to twenty persons in training at one time unless a high proportion of these clients are retarded or extremely difficult cases.

4. **Vocational Evaluation**

a. Purpose — The vocational evaluation goes a step further than work evaluation, although it is sometimes a part of the work evaluation for an individual who seems to be ready for employment. The needs of the client are carefully identified and related to specific employment areas by isolating a major job family, choosing the most appropriate job clusters from the family, and narrowing the choice down to an immediate recommendation of a job for the client.

b. Personnel — The vocational evaluation is usually performed by a work evaluator or a rehabilitation counselor.

5. **Vocational Training**

Vocational training opportunities exist in a number of different settings such as training programs in public schools, residential schools for the retarded; vocational schools; community colleges; MDTA (Manpower Development Training Act) and other special programs. Some types of vocational training are largely based on classroom instruction, while other types are more individually based. Vocational training may be centered about a specific task, such as how to operate a single piece of equipment, or it may include learning to perform a series of tasks which are involved in the job for which one is being trained. In the past, the mentally retarded have faced a serious obstacle in obtaining training because they frequently do not possess even minimally adequate communication skills. Because of this fact, they have often been unable to gain admittance to vocational schools so as to obtain training in areas in which they would have probably been able to perform adequately with training. Community leaders should encourage the establishment of training programs for which retarded individuals can qualify.

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[1] Salvatore G. DiMichael, Ed. *Vocational Rehabilitation of the Mentally Retarded* (Washington, D. C.: U. S. Government Printing Office, 1950), p. 128.

6. **Employment in a Work-Oriented Facility**

   a. **Temporary Employment** -- There are some disabled persons who are capable of working in a sheltered setting but are not yet ready for competitive labor due to behavioral or attitudinal problems, personality factors, slowness, etc. Such an individual may be assigned to work in a work-oriented facility temporarily, until he has improved to the point of being acceptable for competitive employment. During this time he works on the production line under the supervision of a foreman and is paid a salary.

   b. **Extended Employment** — A few handicapped persons are obviously unacceptable to the competitive labor market and, for various reasons, may never be able to work other than in a sheltered setting. They work alongside the people who are placed in the work-oriented facility temporarily; and they, too, are paid a salary. Some of these persons become reliable, productive workers over a long period of time. If such an individual improves to the degree that he would likely be able to work successfully outside the facility, he should be urged to do so.

7. **On-the-job Training**

Job training is usually at its best when it takes place in an actual job setting rather than in a simulated environment. On-the-job training gives the individual opportunities to work under the pressures he would ordinarily be expected to work under, and to work with the same people and under the same supervisor, as if he were actually employed. During the training period, the client is paid a salary. It is paid to him by the employer, but employers, in turn, are sometimes paid to train the client by the

Division of Vocational Rehabilitation. On-the-job training is particularly helpful to many retarded persons because it gives them concrete experience in adjusting to a new environment and learning new routines.

8. Placement Services

Job placement is an important part of the rehabilitative process. Other services may be of little or no value without successful placement and employment. The mentally retarded often have difficulty finding employment and require assistance from the rehabilitation counselor, Employment Service counselor, or others. In some cases the professional person may be able to inform the retardate of job openings which seem appropriate and make suggestions about how to dress for interviews, what to say, and how to act. In the case of more seriously retarded person, however, the counselor will usually talk with perspective employers himself before suggesting that the client arrange interviews.

a. **Factors to be Considered in Job Placement** -- It is generally better to make no placement at all than to place a retarded individual in a job which is inappropriate and in which his chances of success are poor. Performance of the retarded client and not sympathy for him should be the criterion for judging his vocational success. If the client is unhappy with his job or is unable to keep it, his confidence and courage which have taken much time and effort to develop may be destroyed very quickly. Therefore, numerous factors such as those listed below should be given careful consideration before a placement is made:

(1) The client's motivation to work; his goals, desires, interests, dislikes

(2) The client's capabilities and skills; his knowledge and previous training or experience

(3) The client's personality and ability to work with others

(4) The degree of supervision needed; the client's ability to learn new processes and to follow instructions

(5) Acceptability of the client's appearance, language, personal habits, and work habits

(6) The location of the job, and the work environment (for example, transportation demands and the client's ability to get to work alone or with assistance)

(7) The employer's understanding of retardation, his interest in the client, tolerance level, etc.; the counselor can do much to improve the employer's attitudes toward and understanding of the disabled.

b. **Types of Jobs** — Research has indicated that the mentally retarded are more likely to be successful in their work if they are placed in certain jobs. Of course, the appropriateness of a job is an individual matter, but patterns emerge which may be of some value to persons working with the mentally retarded in job placement. In *Vocational Rehabilitation of the Mentally Retarded*, the most common areas of work of the retarded are presented according to the level of dependence and skills required, with specific jobs listed under the headings of "Dependent Workers," "Unskilled Workers," and "Semiskilled Workers." This book also gives a summary of tasks which persons of given mental ages can usually perform, and of the tasks involved in certain jobs.[1] Certainly individual differences among the retarded should not be overlooked because of the generalities presented in this book.

(1) Household workers
(2) Laundry workers
(3) Hotel workers
(4) Shoe repairmen
(5) Food preparation and service
(6) Garment trades
(7) Building maintenance and operation
(8) Motor vehicle maintenance and operation.

1. Follow-Up Services

Follow-up services are particularly valuable for the mentally retarded. The retarded are likely to become discouraged and will need a great deal of support; and their employers may tend to grow impatient with them and want to "give up." The counselor can do much through on-the-job visits and conferences with both the retardate and the employer to smooth out difficult situations before they become overpowering.

D. TYPES OF FACILITIES OR INSTITUTIONS PROVIDING THESE SERVICES

The services mentioned above are available through a number of different sources. Some facilities provide all of these services, while other facilities and some institutions provide one or more of them.

1. The Comprehensive Work-Oriented Facility

The comprehensive work-oriented facility offers a full range of vocational services in cooperation with the Division of Vocational Rehabilitation. Rehabilitation counselors placed in the facility usually provide vocational counseling, placement, and follow-up services and can arrange for on-the-job training. Personnel employed by the facility provide the other services.

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[1] Federal Security Agency. *Vocational Rehabilitation of the Mentally Retarded* (Washington, D.C.: U. S. Government Printing Office, 1950), p. 99 ff.

2. Other Work-Oriented Facilities

The workshop is one type of work-oriented facility. A "work-oriented facility" includes any facility which provides vocational services, even though these services are not their primary area of interest. For instance, many facilities (e.g., hospitals, rehabilitation centers) provide vocational services in addition to medical and other services. These facilities usually cooperate with the Division of Vocational Rehabilitation and have one or more rehabilitation counselors who have offices in the facility. The counselors provide for vocational counseling, placement, follow-up, and on-the-job training. The facility usually employs at least one work evaluator and personal adjustment teacher. Patients in work-oriented institutions such as state hospitals are often assigned to certain jobs in the facility, perhaps as assistants in the laundry or in food preparation. This type of experience offers an opportunity for growth and learning on the part of the patient, and represents a source of valuable information for the vocational personnel covering vocational abilities and weaknesses of the individual.

3. Public and Private Schools

Vocational services are rendered by some of the Special Education units in public high schools and are usually a part of the curriculum in residential schools for the retarded. An increasing number of schools are initiating work-study programs, whereby students are in school half the day and on a job half the day. This may entail holding a job within the school, being placed in on-the-job training, or holding a regular part-time job in the community. Of course, the youngsters in these programs have access to vocational testing, and adequate supervision, which is provided by the school guidance counselor or rehabilitation counselor.

4. Vocational Schools

During the last several years there has been a rapid increase in the number of vocational (trade or technical) schools. Some of these schools offer training for a number of different vocations, while others specialize in training for a single trade. These schools are usually geared toward training high school graduates for a vocation, but some of them accept students with less than a high school education for certain fields of study if they meet minimum test score requirements. A few mildly retarded individuals have enrolled in these schools and have been trained successfully. More retarded individuals might be able to function well in a particular vocation if they could obtain training. Because of admission requirements to an appropriate school, which the retarded cannot meet, they must be trained in work-oriented facilities, MDTA training programs, etc.

E. SUMMARY

Retarded individuals can live a more normal, productive, satisfying life if they are able to work; and most retarded people can work effectively if they are provided with adequate vocational services. Communities and special facilities, institutions, and governmental agencies should be encouraged to expand and to upgrade their vocational services or to initiate such services if they do not already have them. These programs can usually be most successful and most easily implemented when developed in cooperation with the rehabilitation agency.

CHAPTER VI
THE TOTAL COMMUNITY MILIEU

A. IMPORTANCE OF COMMUNITY MILIEU TO THE RETARDED

Mental retardation is a large-scale problem in our country. It results in unhappy, useless lives for many retardates, and tremendous burdens for their families. It is a source of many social problems in our society. It is an economic liability in that so many retarded persons do not work and a large number must live in tax-supported institutions for most of their lives. The overall development of most retardated individuals seems best when they are able to remain in their home community, whether with their family or elsewhere, and to be actively involved in community life. Community involvement includes being a part of the labor market (even if in a sheltered setting), being a part of the spiritual aspect of community life, and participating in recreational activities and social events (even if they are limited to the retarded). Being involved in community life gives the retarded person a sense of belonging and of being needed and cared for, of independence and confidence, and of accomplishment.

B. THE IDEAL COMMUNITY

The ideal community provides for the needs of all its citizens insofar as this is practical and possible. An ideal community is never realized; it is never satisfied with its status, but realizes that it must constantly expand and change. Community planning is centered around the individual and his needs — all of his needs. Consideration is given in the ideal community to total community needs and to the contributions of individual parts to the total community milieu.

C. WHAT THE COMMUNITY CAN DO FOR THE RETARDED

Community leaders should encourage the development of the various types of programs and services for the retarded that have been discussed in this publication. However, they should keep in mind that each of the foregoing leaves one essential element untouched. If the retarded person has access to all of the services described, he may still be unemployed and feel unaccepted if the community as a whole does not exhibit sound, positive feelings toward the mentally retarded. Educating the general public about mental retardation is a necessity if proper attitudes are to be developed. The public should be informed about the causes of retardation, what the retarded person is like, what his needs and assets are, and how individual citizens and the community as a whole can help prevent retardation and assist the mentally retarded.

D. THE COMMUNITY IS HIS "PLACE"

Paul Tournier, a leading psychiatrist of our day, contends that one of the most basic of all human needs is a place — a place which one can call his own and in which he feels at home, whether it is a room, a building, or a "place" in a broader sense. Man has a great need for a place and is always seeking a place. "He stands, in short, in need of a place in order to become a person."[1] A community may well be the only possible "place" with which many retarded persons can identify, and it should be the type of community which would encourage such identification.

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[1] Paul Tournier. "A Place for You" (Guideposts, June, 1966), pp. 1-5.

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THE WORK-ORIENTED REHABILITATION FACILITY

IDEAL SERVICES SERIES

VOLUME IV

BY

JACK M. SINK

ROBERT COUCH

JOEL ANDERSON

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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STATE DEPARTMENT OF EDUCATION
Division of Vocational Rehabilitation
Rehabilitation Facilities Section

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FOREWORD

This volume, the fourth of the Ideal Services Series, deals with the work-oriented rehabilitation facility. It is an outgrowth of the workshops and rehabilitation facilities planning project initiated by the Division of Vocational Rehabilitation in July, 1966, and it will be presented as a guide to all interested persons involved in workshops and rehabilitation planning.

Growing public interest in total rehabilitation has resulted in a rapidly increasing number of disabled persons being referred for vocational rehabilitation services. In addition, a longer period of evaluation is possible to determine an individual's maximum level of functioning. Vocational objectives have been broadened to include other than full-time competetive employment. The planning of vocational services for the severely and multiple disabled often points up the need for a controlled, realistic work environment where professional rehabilitation services can be concentrated more efficiently and effectively.

The program of services suggested in this volume is intended to meet these needs in a manner that will provide greater services to an increasing number of severely disabled people. It is written to provide guidance for interested community groups in establishing services where they do not exist or in the upgrading of existing services. The material is specific enough to give concrete assistance in administering a program without limiting individual creativity.

ABOUT THE AUTHORS

Jack M. Sink is a native of West Virginia. He received his B. A. and M. S. Degrees from West Virginia University and has done postgraduate work at the University of Florida and Auburn University.

Mr. Sink has been a comprehensive rehabilitation center counselor, general rehabilitation counselor, director of halfway houses for the mentally ill, state hospital team counselor, supervisor of a facility for the mentally retarded, and a state rehabilitation facility specialist. He served as charter chairman of Region IV Council of Facility Specialists.

Mr. Sink is currently the director of Rehabilitation Services Education at Auburn University, Auburn, Alabama.

Joel Anderson is a native of Kansas. He received his Bachelor of Science in Industrial Arts and Master of Rehabilitation Counseling Degrees from the University of Florida and has done postgraduate work at Auburn University.

Mr. Anderson has been a vocational evaluator and coordinator of rehabilitation services in a work-oriented rehabilitation facility.

Mr. Anderson is presently assistant professor of Rehabilitation at Auburn University teaching workshop and rehabilitation facility administrators in Auburn University's Regional Workshop and Rehabilitation Facility Training Program.

Robert Couch is a native of Alabama. He received his Baccalaureate and Masters Degrees from Alabama College and has done postgraduate work in Rehabilitation at New York University, the University of North Carolina, and Auburn University.

He has been supervisor, facility counselor, and placement specialist in a special rehabilitation project developing a Workshop Adjustment Training Program. Mr. Couch is the author of a report on this project entitled "A Method for Evaluating and Adjusting the Emotionally Handicapped and the Older Disabled Worker."

As a rehabilitation counselor with the Alabama Division of Vocational Rehabilitation, he served as a general and special disability counselor. In this capacity, he aided in the development of special rehabilitation facility programs for the mentally ill and the educable and trainable mentally retarded.

Mr. Couch is currently assistant professor of Rehabilitation at Auburn University and teaches work evaluators and personal adjustment instructors in Auburn University's Regional Training Program.

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A final debt of gratitude is due our families for their patience, concern, understanding, and assistance during the writing of this volume.

CHAPTER I

PLANNING FOR A WORK-ORIENTED FACILITY

A. INTRODUCTION

Many work-oriented facilities have been established throughout the country by groups of emotional individuals who suddenly decided that a new facility was the immediate answer to problems of our society or of some particular group. In most cases, facilities established under such conditions have soon faltered, or they had to be given new direction. A facility can be an outstanding asset or a "sore thumb" to the community, depending upon the quality of the initial planning. The success of any facility is largely dependent on conducting a thorough study of the community which it is to serve and carefully planning for services which will meet the needs of the community.

B. DETERMINATION OF NEED

The community in which the proposed facility will be located should be examined in order to assess present and future needs which might be met by a work-oriented facility.

1. Types of Information Needed

The survey of the community should be geared toward obtaining the following information:

a. **Prevalence** — The number of disabled people in the community will be needed. This number should include all age groups for the benefit of future planning as well as present planning.

b. **Disability** — The data should include information on the types of disabilities found in the community and the number of persons with each type.

c. **Number of Disabled Who are Employed** — Some "disabled" persons are employed in satisfactory jobs and are well adjusted so they do not require additional rehabilitation services. It is important to know how many of the community's disabled citizens are in this category.

d. **Personal Data**—Information is needed regarding such items as the age, sex, and improvement potential of persons who need rehabilitation services.

e. **Transportation** — The availability of public transportation to and from the proposed facility should be taken into consideration.

f. **Attitudes of Employers** — The survey should assess the prevailing attitudes of community employers about hiring the handicapped and should evaluate the availability of employment opportunities in the community for persons who have been prepared for work by the work-oriented facility.

g. **Residential Accommodations** — The availability of adequate residential facilities which are satisfactorily located should be investigated.

h. **Professional Personnel** — The survey must include a study regarding whether or not appropriate professional personnel to staff the facility can be obtained.

i. **Services** — Existing services of social and medical facilities, and plans for the development of new services or service agencies, should be surveyed.

2. Programs and Persons to Be Contacted

Agencies, programs, and persons such as the local Vocational Rehabilitation office, the Florida State Employment Service office, Department of Public Welfare, Crippled Childrens Commission Clinics, schools, physicians, mental health clinics, parole officers, and the leaders of various societies for special disability groups should be contacted and surveyed. They will be particularly helpful in identifying the services which exist and additional ones which are needed.

C. SELECTION OF PROGRAM DESIRED

1. Method of Selecting Program

If the survey demonstrates the need for a work-oriented facility in the community, a planning committee should be appointed. This committee should be responsible for surveying the community further and recommending the type of program to be carried out within the facility.

2. The Planning Committee

The planning committee will perform a very important function; therefore, it is imperative that this committee be truly representative of the community and its various interest groups. The planning committee should include persons from medical, educational, and social agencies; civic clubs; and groups who will be able to offer financial and technical assistance in the planning for and development of the facility. Some of the specific groups which should be represented are listed below:

a. **Vocational Rehabilitation Agency** — Most referrals to the work-oriented facility will be made by personnel in the local Vocational Rehabilitation office. Therefore, the rehabilitation representative should be included in planning in its earliest stages.

b. **Medical Services Agencies**
   - (1) Mental Health Clinics
   - (2) Crippled Childrens Commission Clinics
   - (3) Department of Public Health Office
   - (4) Clinics for the Mentally Retarded
   - (5) Hospitals
   - (6) Speech and Hearing Clinics
   - (7) Other Medical Facilities

c. **Industries and Chamber of Commerce**

d. **Social Agencies**
   - (1) United Fund or Community Chest
   - (2) Family Service Agencies

e. **Educational Programs**
   - (1) Local Public Schools
   - (2) Trade Schools
   - (3) Technical Education Programs
   - (4) Special Education Programs of Schools for the Retarded

f. **Civic Clubs, Churches, and Leaders of Youth Organizations**

g. **Bar, Bank, and Realtor Associations**

h. **City and County Officials** — The Chief of Police should be one of the persons selected to represent city and county officials. The Mayor might be asked to write letters to the persons selected, asking them to serve on the planning committee as a favor to him.

i. **Labor Organizations**

j. **The Press, Radio, and Television**

3. Procedure for Selecting Type of Program

Members of the planning committee should be informed at the outset of the various types of programs which could be offered. The representative from Vocational Rehabilitation might be asked to discuss the kinds of work-oriented facilities which have been developed in the state and to evaluate their success or failure. It is advisable for some of the members of the planning committee to visit several facilities recommended by the State Division of Vocational Rehabilitation.

4. Single or Multiple Disability Program

Many facilities for single disability groups have been established; but, in general, facilities for persons with a variety of disabilities have been far more successful. Of course, the controlling factors are the services needed as demonstrated by the survey, potential financial support from the community, and the availability of certain types of professional personnel.

D. CHARTER, CONSTITUTION, AND BYLAWS

1. The Charter

Prior to soliciting funds, hiring staff, or selecting a site, application should be made for incorporation as a non-profit social agency. This will allow the facility the full privileges accorded to non-profit, charitable, religious, educational, or philanthropic organizations. The committee's representative from the local Bar Association can be of service in drawing up the proposed certificate of incorporation.

2. The Constitution and Bylaws

a. **The Board of Directors** — The constitution and bylaws should provide for a minimum of fifteen and maximum of twenty-four persons to be selected and designated as the Board of Directors. Since the Board of Directors has many functions, it is desirable to divide the board into committees. Each committee will have a chairman and selected officers, and the chairmen and officers of all the committees will compose the Executive Committee. Suggestions for the various committees are presented below.

(1) **Staffing Committee** — This committee will be responsible for recruiting and recommending the employment of all staff members. They will draw up personnel policies, positions and requirements, annual leave and sick leave regulations, etc.

(2) **Program Committee** — The program committee will make the ultimate decision regarding the type of program to be provided by the facility. It will outline the program to be undertaken, the number of clients to be served, and equipment needed to provide the planned services. Also, it will make arrangements for supportive services from other organizations and agencies of the community.

(3) **Legal Committee** — This committee will be responsible for drawing up the charter, negotiating the lease for the

building if it is to be leased, obtaining wage and hour certificates, and making the appropriate arrangements with Workmen's Compensation and other insurance agencies.

(4) **Budget Committee** — This committee will develop the budget for the total operation of the facility.

(5) **Building Committee** — The building committee will be responsible for the many aspects of selecting a site, planning and constructing a building, or selecting an existing building and remodeling or altering it to meet the standard specifications regarding architectural barriers and safety.

(6) **Finance Committee** — The finance committee will assume responsibility for raising the necessary community funds to assure initial and continuing support of the facility.

(7) **Community Relations Committee** — This committee will work toward continual development of community resources, striving to assure community involvement in the facility and to maintain balance between the community and the services rendered by the facility.

b. **Other Provisions of Constitution and Bylaws** — Details regarding the following aspects of the facility operation should be included in the constitution and bylaws:

(1) Name and Location of the Facility
(2) Purpose of the Facility
(3) Management
  (a) Election of Board of Directors
  (b) How Vacancies on the Board will be Filled
  (c) Frequency of Board Meetings (should meet at least every quarter)
  (d) Annual Meeting Date
  (e) Responsibility for Notices Regarding Meetings
  (f) Quorum at Meetings of Board
  (g) Voting Procedures (all decisions to be made by vote)
  (h) Officers of the Board (names, method of election, duties)
(4) Standing Committees
  (a) Method of Appointment
  (b) Length of Term
  (c) Responsibilities
(5) Executive Director
  (a) Arrangements for his appointment by the Board
  (b) General Responsibilities
  (c) Accountability to Board of Directors
(6) Handling of Funds and Securities
  (a) Official Signature for Checks, Contracts, or Credit

(b) Depositions (regularity and depository)
(7) Specification of the Fiscal Year (when it begins and ends)
(8) Procedure for Amending Constitution and Bylaws*

E. SELECTION OF STAFF

The executive director will be responsible for recommending to the staffing committee specific individuals for employment, and he will have the authority to disapprove the employment of any applicant. The executive director and staffing committee must recommend employment of all new staff. The executive director will then make final arrangements for the employment of the prospective staff member.

F. MANAGEMENT OF FINANCES

The product of any work-oriented facility is its clientele, not financial profits. Its primary purpose is to provide services to handicapped people to the extent that they will be able to compete for employment in the open labor market. The community should realize that even though there may be some productive work in the facility, its main objective is not to make a profit. Any deficit resulting from the facility operation is one of the community's responsibilities in providing services for the disabled citizens of the community. Therefore, the community should be made aware of the financial obligation involved.

1. Means of Financial Support for the Facility

a. Sources of Funds within the Community — Some of the best potential sources of local funds are:

(1) Community Chest or United Fund
(2) Endowments
(3) Civic organizations and clubs
(4) Governmental allocations (many county delegations and city governments make annual allocations to facilities)
(5) Private grants made by individuals, industries, and businesses
(6) The provision of free staff (from clinics and educational establishments)

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*For a detailed sample of the constitution and bylaws, see Appendix.

b. **Other Sources of Funds**

(1) Federal grants such as those available through the Division of Vocational Rehabilitation
(2) Fees for services rendered to clients
(3) Production revenue (income from sales or contract work)
(4) Various state societies for special disability groups
(5) Business and Industry

2. Areas of Budgetary Needs

The budget committee should be mindful of four general areas of budgetary needs:

a. **Professional Staff and Services** — This area includes the salaries of all professional staff, expenses involved in providing medical services, and the cost of any transportation which is provided.

b. **Expenses of Operation** — Operation costs include such items as repairs, utilities, and the salaries of all personnel dealing strictly in supervision of production.

c. **Revolving Fund** — This fund should be available for the wages of disabled persons employed in the facility, raw materials used in production, supplies, and other items which are reimbursable.

d. **Capital Funds** — These funds will be used to purchase or lease the building site and to purchase furniture, machinery, tools, and other equipment.

CHAPTER II

COMMUNITY COOPERATION AND SUPPORT OF THE WORK-ORIENTED FACILITY

A. ROLE OF THE COMMUNITY

The role of the community cannot be over-emphasized in the development and continual support of the work-oriented facility. Regardless of the degree of effort put forth by the Board of Directors, the total community is still responsible for referring appropriate clients to the facility, accepting the handicapped as equal citizens of the community, employing them in business and industry, and supporting the facility financially.

B. COMMUNITY RESOURCES

The Board of Directors and the executive director should call upon every available community resource in order to assure optimum community interest. Some of these resources are:

1. Community Organizations and Clubs

Usually the community council will have a list of all the organizations within the geographical area which it serves. The executive director of the facility and the members of the facility's community relations committee should offer their services to the program committees of all community organizations. When this is possible, the facility may plan teas or luncheons and invite organizations who are interested in visiting the facility. Cultivation of the interest of one or two key leaders of each organization will usually result in the development of an interest on the part of the entire organization. Once these organizations are interested, they will be able to contribute in many ways such as providing volunteer workers, making monetary contributions, and helping to inform the general public about the handicapped and about the work-oriented facility in particular.

2. Other Community Groups

Many industries, businesses, foundations, private agencies, and public agencies will be helpful if they are brought to a full understanding of the facility and its objectives. They may contribute funds, provide additional personnel for the facility, arrange contractual business with the facility, or employ handicapped persons whom the facility has prepared for work. Some professional services may be obtained from other agencies in the communities. The availability of professional personnel and services from various resources can probably be discovered by means of the survey described in Chapter I.

C. PUBLIC EDUCATION AND READINESS

1. Educating the Public

The greatest deficit in rehabilitation programs is usually an uninformed public. A community education program is essential, and it should be designed not only for initial support and development of the facility, but also for continued support. Of course, this calls for on-going efforts to educate the public in regard to rehabilitation and the work-oriented facility and to keep citizens interested and informed.

a. **Types of Information** — The public should be aware of answers to questions such as these:

(1) How many handicapped individuals live in the community?
(2) What kinds of handicaps do they have?
(3) What types of services do they need?
(4) Who will provide the professional services needed?
(5) What are future needs in regard to services?
(6) What is the overall goal in the rehabilitation of handicapped people?
(7) What will be done for the handicapped by the work-oriented facility?
(8) What is expected of the community in regard to this facility?
(9) How will the facility be financed?
(10) Who is on the Board of Directors?
(11) What professional personnel will be working in the facility?

b. **Methods of Educating the Public** — The public relations committee should avail itself of the services of the press, radio, television, and newsletters of organizations. The committee should also request permission to speak at regularly scheduled meetings of various civic groups, social and service organizations, the city council, legislative delegation, schools, religious organizations, the community council, and any other group who is interested in community affairs.

2. Community Readiness

It is easy for the planners of a facility to become overzealous and move at a faster pace in the development of the facility than that for which the community is prepared. Many times the community moves at what appears to be a snail's pace, and this is discouraging to persons involved in planning; but until the community is ready, the facility should not be established. Once the community is totally ready, it will be almost impossible to prevent the establishment of a needed facility. Such readiness as this is reassurance of the success of the facility.

D. COOPERATION WITH THE COMMUNITY

The program of the facility should not be planned and carried on exclusively by the facility, but by the community as well. It should be flexible enough to allow for changes, additions, or deletions in services when the need for these are suggested and substantiated by community groups.

1. Cooperation with Agencies and Organizations

It is the responsibility of the executive director to maintain communication with leaders of organizations and agencies who are vitally interested in serving the handicapped of the community. When a client of the work-oriented facility is being staffed, representatives of the agency which referred him might be invited to attend; this is one method of better informing agencies about the services available to their clients through the work-oriented facility. In return, most organizations and agencies will invite representatives of the facility to attend their planning sessions. Through cooperation such as this, overlapping of services among agencies will be minimized, and optimum planning for future services will be possible.

2. Cooperation with Labor Organizations

The primary purpose of any work-oriented facility is to prepare handicapped people for employment. The employment standards in business and industry are frequently set by labor organizations; therefore, the facility personnel should strive for optimum cooperation with labor organizations which represent the fields of work found in the community. Representatives of labor organizations are usually willing to serve on the board or to consult with the director of the facility. The director or a representative of the community relations committee should seek opportunities to speak to labor members at their scheduled meetings.

3. Cooperation with Industry and Business

A good work-oriented facility is able to evaluate and train the handicapped individual for employment in a specific industry or business. On the other hand, actual employment of the handicapped person in the job recommended as a result of evaluation and training is dependent upon full cooperation of the industry or business. The evaluator should spend at least two days each month reviewing jobs in the community. The contract procurement specialist is also in frequent contact with representatives of industry and business. Industrial and business specialists (bookkeepers, engineers, accountants, sales specialists, etc.) are often willing to serve as consultants (without cost) to the facility. In this way, they learn a great deal about the facility which will further enhance cooperation.

4. Cooperation with Civic Groups

Civic groups are made up primarily of community leaders who organize for the purpose of providing services needed by the community. Therefore, the work-oriented facility and civic groups have a great deal in common, and, through cooperation, both will be able to more nearly provide optimum services. An open invitation should be extended to all civic groups to visit the facility during one of their regular meetings. Also, the facility director or a member of the community relations committee should seek an opportunity to speak to each civic organization.

CHAPTER III

SERVICES OF THE WORK-ORIENTED FACILITY

A. THE ROLE OF SERVICES

Rehabilitation services in the facility are geared toward meeting the many needs and problems presented by the individual handicapped client. The services of the facility are designed to prepare the handicapped person to enter the world of work, and all activities of the facility should be pursued with this in mind. The ultimate goal of the ideal facility is not goods or services, which are incidental to facility activities, but producing handicapped persons who have learned to live, work, and function adequately in our work-oriented society.

B. INTAKE PROCEDURES

Referral and intake procedures should be designed in such a way as to permit the referring sources to present to the facility any available background data regarding work, social, personal, and medical history. The facility staff should obtain further information relating to the goals of the client and his family. Together, this information should be sufficient to give the facility staff a workable understanding of the individual and his particular needs. With this material in hand, the staff should consider the following aspects:

1. Questions of the Source of Referral

The referring agency or individual may have specific questions regarding a particular client or the services of the facility in general. An effort should be made to answer these questions as soon as possible.

2. Initial Goals for the Client

The staff should immediately determine initial goals for the client in order to develop the program of services around these goals. The goals and services may be adjusted later if necessary.

3. Special Problems of the Client

Consideration should be given to any special problems of the individual client such as medication, transportation, housing, etc.

4. Arrangements for Services

Intake procedures should be geared to facilitate the client's admission to the facility and his early orientation and adjustment to its program. The staff member responsible for intake procedures should make arrangements for the following:

a. Interviewing the client
b. Touring the facility
c. Introducing the client to the staff and other clients
d. Operational hours
e. The clients' assignments
f. Compilation of all appropriate records

C. WORK EVALUATION

Work evaluation is the process of having the client try different jobs or samples of work and collecting information about his work history, education, and physical condition. This is done in order to determine his employment potential, major assets, aptitudes, and specific problems interfering with his readiness for employment. Methods for attaining these work evaluation goals are discussed below.

1. Testing

Testing is a function of the psychologist, but a trained work evaluator can administer many of the psychometric tests. Standardized tests may be administered to assess the client's mental capacities, interests, and aptitudes.

a. **Intelligence Tests** — Intelligence tests measure the client's mental ability and can serve as one indication of his future level of vocational functioning. Tests such as the Wechsler Intelligence Scale, Slosson Intelligence Test, and the Beta Revised are examples of many intelligence tests which are available.

b. **Vocational Interest Tests** — These tests are helpful in detecting broad areas in which the client is most interested. Although the tests often reveal inconsistencies, general patterns emerge. An example of interest tests is the Kuder Preference Record.

c. **Educational Achievement Tests** — Tests may be administered to determine an individual's level of academic achievement. Popular examples are the Wide-Range Achievement Test and the Stanford Achievement Test.

d. **Vocational Aptitude Tests** — The Differential Aptitude

Test, Bennett Mechanical Comprehension Test, Minnesota Clerical Test, and other tests are helpful in obtaining information regarding areas in which the client has the greatest potential. The General Aptitude Test Battery used by the State Employment Service is another test of this type which the work-oriented facility may encompass in its work evaluation program.

e. **Dexterity Tests** — Dexterity tests reveal the client's ability to manipulate objects with the hands and fingers. The Purdue Peg Board and Crawford Small Parts Dexterity Test are popular tests of this type.

f. **Personality** — Behavior, abnormalities, and attitudes can be examined by utilizing such tests as the M.M.P.I. (Minnesota Multiphasic Personality Inventory) and the Rorschach. These two particular tests should be administered only by an experienced psychologist, pschometrist, or psychiatrist.

2. Making Clinical Judgments

Judgments of other facets of the individual and his vocational capabilities are made by the work evaluator and other facility personnel by carefully observing the client, reviewing case data, and interviewing the client and his family. Information is sought regarding:

a. Client and family attitudes
b. Physical tolerance
c. Interpersonal relations with facility personnel, other clients, etc.
d. Client motivation and aspirations

3. Evaluating Job Readiness

The term "job readiness" refers to person's possessing suitable work, social, and personal habits. The activities in which the client is engaged during the course of the work evaluation are designed to reveal such habits as these. For example, many habits of the client are revealed as he works on various facility contract jobs or as he participates in social and off-hour activities. In evaluating job readiness, the client's past records of vocational, social, educational, and personal achievement are taken into consideration, as well as his appearance and work habits.

4. Work Samples

Work samples are utilized to aid in the selection of specific job or training areas in which the client may be placed or trained. Jobs can be sampled in several ways.

a. **Simulated Work Sample Tests** — Work sample tests are designed to measure the client's capacity and ability to perform specific tasks involved in various types of jobs. The work samples should be selected very carefully in order to assure meaningful results. In selecting them, these steps should be followed:

(1) **Survey** — A survey should be conducted to determine what jobs in the community are available to facility clients.

(2) **Literature** — Current occupational literature should be reviewed.

(3) **Identification of Worker Traits and Skills** — An analysis of jobs and training areas should be performed to identify the work traits and skills necessary for specific areas of work.

(4) **Setting up of Samples** — After completion of these three steps, work samples should be constructed to measure the traits and skills required by each specific job or training area.

b. **Sampling of Jobs within the Facility** — Jobs within the facility which have counterparts in the community are suitable work samples and provide valuable information regarding the client's performance.

c. **Job or Training Tryouts** — Tryouts in specific jobs or training programs in the community offer another means of evaluating the client's readiness for employment or training. Trying out jobs in a real, competitive setting has the advantage of presenting the identical pressures with which the client will have to cope after obtaining competitive employment.

5. Utilization of Counsultants and Counselor

Appropriate consultants such as psychologists, physicians, and industrialists should be included in the evaluation process when appropriate, and the client's rehabilitation counselor should be consulted from time to time through the evaluation process. Staff conferences are mandatory in order to synthesize data, review goals, make plans, and reach team decisions relating to the client's work evaluation.

6. Work Evaluation Report

The work evaluation report should be very specific, clear, carefully worded, and neatly typed.

a. **Clients Ready for Employment** — For those clients demonstrating a readiness for employment, several specific jobs or training areas should be recommended.

b. **Clients Not Ready for Employment** — For clients demonstrating little or no potential for employment, recommendations should be made for obtaining further facility or community services, i.e., sheltered employment, activity center services, welfare services, etc.

c. **Clients Able to Work But Not Job-Ready** — For clients who have demonstrated potential for employment but lack of job readiness, the obstacles to employment should be listed. A proposal for an adjustment training program should be outlined with specific recommendations given to eliminate, circumvent, or minimize problems interfering with employment readiness.

D. PERSONAL ADJUSTMENT TRAINING

In personal adjustment training, a disabled person is helped to understand, accept, and remedy conditions or attitudes which interfere with his securing and holding a job. Personal adjustment is taught by professional individuals specifically trained in the area of interpersonal and behavioral relationships. They should receive appropriate consultation from a psychiatrist or a psychologist.

1. Personal Adjustment Program and Teacher

The work-oriented facility must have a separate personal adjustment training program with a staff member who is responsible only for its implementation. One teacher can train no more than twenty individuals simultaneously.

2. Personal Adjustment Activities

The personal adjustment training program includes a wide range of activities designed to aid the handicapped client in overcoming his particular obstacles to employment. Some of the activities are discussed below.

a. **The "Real Work" Program** — Learning to accept responsibility for a job and experiencing the demands, stimulation, and rewards of work are the basic ingredients of a personal adjustment training program. By actually working, the client learns to cope with work pressure, deadlines, supervision, and working with others.

b. **Behavior Modification** — A program for behavior modification should promote readiness for employment by applying psychological concepts to change behavior.

c. **Counseling** — Both individuals and group counseling by the rehabilitation counselor are integral parts of the total personal adjustment training program. An effort is made to help the client see his strengths and weaknesses realistically, to encourage and guide him as he tries to improve, and to involve him in vocational goals and plans.

d. **Job Readiness Classes** — These classes emphasize the characteristics of a good worker, how to approach job interview, group and individual problem solving, hygiene, grooming, personal finances, etc. Role-play, visual aids, outside consultants, and other resource persons and techniques are utilized to effect the goals of personal adjustment training in job readiness classes.

e. **Life Adjustment Services** — A program of life adjustment services should be organized to aid the client in learning to live and work in the community with his fellow man. These services should be integrated into the community in which the client must ultimately function. Some examples of life adjustment services are:

(1) A system of "client government" within the facility
(2) Religious activities of the community
(3) Independent living in a domiciliary or community setting
(4) A recreational program

f. **Community Services** — Utilization of community resources can enhance and expand services available to facility clients. Treatment of special problems can be handled effectively by close contact with agencies specializing in certain areas such as Salvation Army, mental health clinics, schools, and recreational programs. Proper utilization of community resources can, in essence, enlarge the facility staff and extend its personal adjustment services.

g. **Social Services** — Social services can provide the vital link between the facility and the client's family. The social worker will become acquainted with the client and his family and visit them in their homes. Solving problems in the usual family environment will often prevent the client from failing in his program at the facility.

h. **Pre-Vocational Training** — Remedial educational programs leading to and including completion of the high school equivalency diploma (GED) literally opens up hundreds of new vocational possibilities.

i. **Continual Reassessment of Client** — Every personal adjustment training program should have provisions for continual assessment of each client's progress toward his goals in personal adjustment training. Appropriate modification of the client's program must be made and periodic progress reports forwarded to the referring source. When the client seems ready for employment, consideration should again be given to work evaluation to determine new or different job areas in which the client could be placed or trained.

E. OCCUPATIONAL SKILL TRAINING

1. Purpose of Occupational Training

Training should be provided which will prepare clients for occupations available in the community served by the work-oriented facility and also for occupations in which future needs have been clearly identified. The facility's training program should be established only after a thorough study of training possibilities which already exist within the community in order to avoid overlapping areas of training. The work-oriented facility setting should provide unique training for persons who could benefit from training but who are presently denied training because of rigid admission requirements, architectural barriers in the training facility, or inflexible training schedules. The purpose of each area of skill training is to provide the client with at least the minimum entry requirements for employment in that particular area; therefore, training should include as many specific requirements of prospective employers as possible. All the training curricula would not necessarily be provided within the work-oriented facility. On-the-job training within the community can be offered concurrently with other facility training.

2. Number of Clients

A determination should be made about the number of clients to be admitted to each training program. Classes should be limited to the number of persons who can be effectively instructed in view of the amount of space and equipment available and the number of training staff.

3. Selection of Clients for Training

Clients selected for a training area should have been thoroughly evaluated as to specific interests, aptitudes, and abilities required for that job, and they should have achieved a sufficient level of personal adjustment to allow them to benefit from the training. Final selection of clients for a specific training program should be made by the facility staff based upon recommendations from the rehabilitation counselor, training instructors, work evaluator, personal adjustment teacher, and other members of the facility staff.

4. The Training Environment

The training environment should be as similar as possible to the industrial setting in which the client will be expected to work when he completes his training. This applies to equipment, lighting, ventilation, and other physical factors of the work environment.

5. Plan of Instruction

There should be a written, well-organized plan of instruction for each specific training area, and this plan should include evaluative criteria at several points in the curriculum. The plan should be individual-centered, and each client should be allowed to progress at his own rate. Provisions should be made for helping the client develop a better understanding of his competencies and weaknesses and how they relate to the requirements of his vocational objective.

6. On-The-Job Training

On-the-job training should be set up as a part of the occupational training program of the work-oriented facility. On-the-job training situations should have specific written curricula and evaluation criteria just as the training programs within the facility do. On-the-job training is a means of expanding the training sources available to the client and of adapting programs to meet the needs of individual clients. It is particularly helpful when the demand for training in a given occupation is not great enough to justify a full training program in the facility.

7. Training Areas

Some training areas which may prove to be appropriate are:

a. Nurserymen (including special skills pertinent for the locale)
b. Mail handlers
c. Nurses' aides and orderlies

d. Custodians
e. Yardmen
f. Filling station attendants
g. Upholsterers
h. Food servants (salads, server, dishwasher)
i. Plumbers, carpenters, masons, laborers
j. Small motor repairmen
k. Welders
l. Laundry workers (washer operator, presser, sorter, etc.)
m. Machine operators

8. Follow-Up Services

Follow-up services are necessary in order to help clients with any problems which arise after placement and in order to evaluate the effectiveness of training. Follow-up services are usually the responsibility of the rehabilitation counselor. However, training instructors should work closely with placement and industry personnel in obtaining follow-up data to use in revising the curriculum as needed to meet the current demands.

F. VOCATIONAL COUNSELING

1. Role of the Rehabilitation Counselor

The rehabilitation counselor in a work-oriented facility setting is responsible for coordinating the programs of all clients within the facility. The rehabilitation counselor should be involved in all major decisions affecting a client and should have an adequate record system which will reflect the findings of the staff and the bases for decisions as they are made. Consultation with professional rehabilitation personnel outside the facility should be available to the staff of the work-oriented facility and coordinated through the rehabilitation counselor. Progress reports to the sponsoring agency and to the center's staff must be maintained at regular intervals. These reports should reflect the client's progress in terms of his objective, and the counselor is expected to assist with them. The rehabilitation counselor in a facility should also provide adequate personal counseling for clients in the program to help them make the adjustments necessary. Adequate support and encouragement should be available to the client to help him better understand the program, his problems, his disability, and the decisions involved in developing a vocational objective for himself. Group counseling may be considered when appropriate for specific needs. Care in selection of group members should be exercised in terms of their ability to benefit from the group.

2. Provision of the Rehabilitation Counselor

The rehabilitation counselor should be provided to the facility by the state Vocational Rehabilitation agency. One or more full-time counselors may be provided to a large work-oriented facility. In smaller facilities where a rehabilitation counselor is provided on a part-time basis, a specific time schedule should be developed so that he will be available regularly and at critical points in the client's program—particularly for initial staffings, staffings at the end of a client's evaluation period, at the time of referral for placement, or when services are terminated. This is the minimum involvement of the rehabilitation counselor and is essential for maintaining the rehabilitation objective of the facility.

G. PLACEMENT

Placement, too, is a responsibility of the rehabilitation counselor. He should be engaged in an active program of job recruitment and development. The goal of the placement program should always be the selective placement of each client at his optimum level. Care should be taken not to put clients into jobs to satisfy an employer's need only, as this may add to the client's failures as well as the employer's lack of confidence in the counselor's ability to recommend suitable employees.

1. Job Analyses

A regular program should be established for the counselor to visit prospective employers. A careful analysis of jobs should be made firsthand of the duties, physical demands, special skills required, emotional stresses and strains, and personality traits of supervising personnel over the specific job. Production demands for quantity, quality, and methods employed should be recorded also. Records of these analyses, along with information on jobs openings, should be readily accessible to the total rehabilitation staff.

2. The Team Approach to Placement

Although the rehabilitation counselor is ultimately responsible for seeing that a client is placed, he must cooperate with other facility staff members, public and private employment service agency personnel, and other persons who know an individual client well enough to assist in the placement process. Training instructors and work supervisors may have industrial contacts and the necessary relationship with the client to successfully place individual clients, but this should be done only with the rehabilitation counselor's approval.

3. Methods of Promoting the Placement of Clients

Placement committees consisting of such persons as the rehabilitation counselor, employment counselor, and various facility staff members may be developed for the entire program or in the case of difficult-to-place clients. Bulletins describing the abilities of clients who are ready for employment may be mailed to prospective employers or advertised over radio and television stations to promote employment opportunities. Public recognition of the employers of successful clients will assist in promoting new opportunities.

4. Helping Client with Details of the New Job

Once a job is determined suitable to a client's interests, motivation, abilities, and capacities, the rehabilitation counselor should provide whatever assistance is required by each client. This may vary from giving the employer's name and address and a job description to the client for his independent action, to actual assistance with the application and interview and working with the client for the first day. The rehabilitation counselor should be certain that all necessary arrangements for transportation, the living situation, payment considerations, etc., are complete when the client begins the job and that guardians of minors or dependent workers are aware of these arrangements.

5. Follow-Up Services

Follow-up of a placement must be made according to the needs of the client. A minimum of 90 days follow-up should be considered part of the placement process, and the client should not be considered placed until then.

H. EXTENDED EMPLOYMENT

This service should be available to two groups of clients—those who are ready for competitive employment and those who will probably not reach competitive employment standards.

1. Persons Ready for Competitive Employment

Clients who are functioning at competitive standards and are deemed ready for employment but cannot be placed immediately should have the benefit of extended employment in the workshop. This is sometimes referred to as "transitional employment." Placement in the work-oriented facility should be such that the client can maintain the level of skills attained in previous training. Of course, the client should be moved on to competitive employment as soon as possible. Clients in this group may be unable to begin employment immediately because of these reasons:

a. The job for which the client trained is not immediately available.
b. Living arrangements are incomplete.
c. There are transportation problems.
d. The treatment scheduled temporarily interferes with full-time employment.
e. The client is awaiting special adaptations of the job for a specific placement.

2. Persons Not Ready for Competitive Employment

The second level of extended employment should be utilized once the rehabilitation staff has determined that the client does not show potential for competitive employment. Changes occur both in the client's ability to perform and in the job market which would allow some of these individuals to function in a very selective, competitive environment later on. A workable percentage of the facility client caseload should be established for this level worker if the work-oriented facility desires to maintain a transitional program. If the community's need for services for this type of client is greater than thirty-five percent of the daily attendance, serious consideration should be given to the establishment of a separate work activity program for clients with the least potential.

I. RESIDENTIAL ACCOMMODATIONS

1. Purpose

Residential accommodations should be available to augment the total program by providing living accommodations, training, and supervision for those clients whose home environment restricts their rehabilitation progress to the point that they might not be successfully rehabilitated if they remain at home. Various circumstances will dictate the need for living outside the home including:

a. Physical proximity to services (too restrictive or prohibitive)

b. Inability of the family members to coordinate the necessary services

c. Attitude of family members such that client doesn't receive the positive stimulation which is essential for him to effectively participate in the program offered.

2. Scope of Residential Accommodations Program

The residential accommodations should be selected according to the needs of the individual client. Some clients may need only food and shelter, while others will require close supervision and perhaps limited nursing services. Services of existing agencies should be utilized wherever possible and augmented with foster homes and halfway houses. All residential programs should promote the development of independent living, and personnel in these programs should work closely with the rehabilitation staff. Satisfactory transportation should be available to and from the residential accommodations. Social and recreational outlets must be available to help in developing all aspects of the client's life.

J. FOLLOW-UP SERVICES

A program of long-range follow-up services should be planned for facility clients. A personal visit to the client and his employer should be made after six months, twelve months, and yearly thereafter, and a record made of the client's progress, changes in job requirements, the employer's comments, and the client's income. The placement counselor should make the follow-up visit; however, other persons, especially the field rehabilitation counselor, may be more appropriate in some circumstances. Social workers, public health nurses, visiting nurses, or welfare workers may assist in gathering follow-up data. This information will be valuable for evaluating the effectiveness of the total program and will serve as a source of information for improving evaluation and training techniques. Also, documented records will be useful for research purposes in developing solutions to problems of the severely disabled and verifying how successful persons with various disabilities have been in certain types of jobs. Another great benefit of thorough follow-up services is the encouragement which staff members receive from being reminded of their successful efforts.

K. SELF-EVALUATION OF SERVICES

1. Purpose of Evaluation

The facility will have a well-defined system for regular evaluation of the quality of services provided to clients. The system will be a part of standard operating procedures and policies and in addition to any accreditation services which may be maintained. Surveys by accreditation organizations can be beneficial in locating problem areas and suggesting improvements, but a more frequent and comprehensive means of evaluation must be used to insure quality service.

2. Suggested Method of Evaluation

One method which might well be adopted would be to have a total staff review of every fifth case closed, no matter what status it was closed in. Higher volume facilities may find that each tenth or fifteenth case would give ample evaluation, but some systematic order without regard to circumstances must be chosen. Each staff member could offer written criticism, followed by the total staff discussing all remarks as a group and arriving at recommended changes which could be implemented readily. Agencies who have purchased services from the facility should be invited to participate in this evaluation.

L. RECORDS AND REPORTS

A central file for housing case data should be maintained to insure confidentiality of medical reports, psychological reports, social history, and other personal information relating to each facility client. Information reported about the client will greatly influence his life and may be used years later in response to contacts made with the facility by the referral source, other agencies, or legal authorities. Reports should document conclusions reached relating to potential for employment, assets, aptitudes, and special problems as well as recommendations for job placement, vocational training, or personal adjustment training. The central file will contain four general types of reports and records—those related to work evaluations, personal adjustment training, the payroll, and special aspects of the facility operation or job placement.

1. Work Evaluation Reports

Preparation of work evaluation reports is the responsibility of the work evaluator. He must collect, synthesize, and communicate facts to the referring counselor or other sources. His report should not simply parrot information received from the referring source, but should be specific and concise and state recommendations clearly. Recommendations for job or training areas should be made in order of priority. These recommendations should be in keeping with the client's capabilities, interests, and motivation, as well as realistic vocational opportunities afforded the client in his community. If personal adjustment training is recommended, the problems interfering with the client's employment readiness should be clearly identified, along with a plan to solve, circumvent, or minimize these problems. The importance of the work evaluation and the report stemming from it can not be overemphasized. Money and time are committed on the basis of the work evaluation recommendations, and the client's future success or repeated failure frequently rests on the validity of this report. In addition to the final report, work evaluation records should include the following:

a. A summary sheet with such information as
    (1) Basic skills (ability to tell time, make a change, and perform other skills of daily living)
    (2) Abilities and habits related to employment
    (3) Results of literacy measurements and other tests
    (4) General requirements of the occupational family recommended for the client
b. Check sheets or rating forms from work supervisors to pinpoint specific strengths or weaknesses
c. Daily anecdotal record (allows isolated facts to merge, forming a total picture of the client).

2. Personal Adjustment Training Reports

Reporting personal adjustment training on a monthly basis keeps the referring counselor informed of his client's progress. This report should relate how the client is progressing toward overcoming his particular obstacles to employment and how the adjustment training plan is being carried out. Any modification of the personal adjustment training plan should be justified in the monthly report. Once the client has become employable, a final report should be forwarded to the referring counselor. Any continuing weakness or any precautions should be noted. Personal adjustment training usually extends over a longer period of time than work evaluation, and it serves a different purpose; however, some of the same forms used in work evaluation may be utilized in personal adjustment training, as long as the difference in purpose is kept in mind.

a. The objectives of the personal adjustment plan should be clearly evident to all facility staff, and daily recording should reflect progress or problems in work toward those objectives.
b. Check sheets or rating scales can be utilized on a regular basis as a measurement of progress.
c. Anecdotal records should be kept to chart daily progress toward individual goals in personal adjustment training.
d. Production records indicating the client's job assignments, rates of production, and how he compares to the standard are important.

3. Payroll Records

Appropriate payroll records shall be prepared and maintained for each client. These shall include:
a. Client identification, pay period, daily hours worked, regular and overtime earnings, additions to or deductions from earnings, net pay, and dates of payment
b. Written records periodically given to the client showing gross pay, hours worked, and deductions
c. Adequate records to validate that pay rates are commensurate with prevailing rates in the community for work of a similar nature and of comparable quality and quantity.

4. Special Records

Special forms or narrative reports should be provided for recording information on a client's performance and behavior while in the residential facility, on training tryouts or an outside job, etc. These forms may also be used by facility staff members other than the work evaluator or personal adjustment teacher to record interesting information on clients or to note employment opportunities in the community.

CHAPTER IV

STAFFING THE WORK-ORIENTED FACILITY

A. IMPORTANCE OF THE FACILITY STAFF

The various activities necessary to accomplish a program of excellence in a facility require the teamwork of individuals with a wide range of abilities, training, and experience. Making the work-oriented facility worthwhile for the handicapped population necessitates a "compatible relationship between professional, technical, and production personnel."[1] The staff members of the facility bring a host of divergent talents into the program, and each person plays an integral role in accomplishing the workshop's ultimate goal of preparing the handicapped client for vocational, social, and personal functioning in society. A specific job description for each staff position should be prepared, and these should adhere closely to the standards established by the National Policy and Performance Council. Qualifications of the following facility staff members reflect those standards as reported in the council's *Standards for Rehabilitation Workshops and Facilities.*

B. ADMINISTRATIVE STAFF

1. Director

The director of a facility must be able to pursue the seemingly divergent goals of service to clients and obligation to business commitments. The director is responsible for all activities and for all staff members of the work-oriented facility. The minimum education required for the director should be a Baccalaureate Degree. The director should have had at least four years of full-time work experience with a minimum of two years experience in administrative work in which he directed professional, technical, or supervisory personnel.

2. Plant Manager

The plant manager should have a minimum of five years experience in industry or a work-oriented facility, and at least a high school education. The plant manager must meet contract and other business commitments. He will supervise the overall production program, maintain quality and quantity control, provide for good safety practices, and supervise machine maintenance. He must cooperate with other facility staff members in meeting both production and rehabilitation goals.

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[1] National Association of Sheltered Workshops and Homebound Programs, *Sheltered Workshops — A Handbook* (Washington, D.C.: National Association of Sheltered Workshops and Homebound Programs, 1966 Rev.) p. 42.

3. Foreman

The foreman or work supervisor works directly with the client in attaining both rehabilitation and production goals. A high school education and four years employment in industry or a work-oriented facility are mandatory. The foreman works directly with the client in the section of the workshop assigned to him. He must insure quality and quantity standards of the handicapped clients in his section.

4. Contract Procurement Specialist

The contract procurement specialist should be a high school graduate with a minimum of four years experience in industrial sales, including experience in estimating and bidding practices. He will meet with industry personnel to secure subcontracts for the facility, conduct time studies in order to calculate prices, and work closely with the plant manager and other administrative staff in procuring and satisfactorily completing contract work.

5. Public Relations Specialist

The public relations specialist must have experience and training in the utilization of communications media, community organization, and fund raising. He will generate public support for the work-oriented facility and will promote financing, placement opportunities, contracts, and other aspects of the facility which are dependent on desirable relationships with the community.

C. REHABILITATION STAFF

1. Rehabilitation Coordinator

The rehabilitation coordinator should have completed a Masters Degree program in rehabilitation services and should have appropriate experience as a rehabilitation counselor, supervisor, and/or two years experience in directing professional personnel.

The coordinator is in charge of the total program of rehabilitation services and works with other professional persons to assure complete and continuing services for the handicapped client.

2. Work Evaluator

The work evaluator's minimum qualifications include a Masters Degree in an appropriate field or an undergraduate degree with appropriate experience in such areas as education, industrial arts, occupational therapy, rehabilitation counseling, psychology, social science, or manual arts therapy. The work evaluator should have appropriate in-service training relating specifically to work evaluation. He will give vocational tests, construct job samples, and perform other professional activities necessary to assess the client's potential for employment in various occupational areas.

3. Personal Adjustment Teacher

The requirements for the personal adjustment teacher are essentially the same as those for the evaluator. This person is specifically trained to help the client understand, accept, and correct the behavior and attitudes which interfere with his obtaining and holding a job.

4. Occupational Skill Instructor

An occupational skill instructor should either be accredited by the State Department of Education or qualify as a journeyman through apprentice training with at least one year of experience in teaching a trade; or he may have similar related experience and training with specialized in-service rehabilitation training.

5. Rehabilitation Counselor

The rehabilitation counselor must have a graduate degree in rehabilitation counseling or a related field, along with two years experience in a Vocational Rehabilitation agency.

6. Social Worker

The social worker should have graduated from an accredited school of social work.

7. Psychologist

The psychologist must have a minimum of a Masters Degree in psychology from an accredited college or university.

D. IN-SERVICE TRAINING

1. Orientation of New Employees

A program of staff development will be provided for each employee of the work-oriented facility. This should begin at the time of his employment with a formal orientation to the history and objectives of the facility. The rehabilitation philosophy of the facility should be made clear, as well as its organizational structure, the scope of its services from initial contact to follow-up, its general policies, personnel policies, and rules and regulations. The specific content and responsibilities of each staff member's job will be reviewed thoroughly and specifically. Orientation to the new job should include trips to at least two similar programs within the state and one outside the state. The facilities to be visited will be selected by the administrator and the new staff member. Training opportunities must be provided for supervisory staff in methods and techniques of supervision and ways of dealing with interpersonal relationships. Contract supervisors should be trained in how to conduct method analyses, time studies, job analyses, and studies of the flow and handling of materials.

2. Continual Learning Opportunities

Staff shall be encouraged to continue their professional education and participation in professional conferences and meetings which bear on their responsibilities in the facility. Opportunities to attend short-term and long-term training institutes should be available to staff members.

3. Utilization of Consultants

Consultants from appropriate fields of specialization and staff of other local agencies can be utilized in providing instruction within the workshop. Primary responsibility, however, must be with the rehabilitation coordinator or another appropriate workshop staff member to insure a continuing and personal training program.

E. STAFF EVALUATION

The quality of services provided are directly related to the personal attitudes and understanding of each staff member. A program of personal evaluation is essential to good communication and proper usage of staff. An evaluation of each staff member's attitudes, effectiveness, strengths, and weaknesses should be completed by his immediate supervisor prior to the end of his probationary employment period, at the end of one year's employment, and annually thereafter. Additional comments may be made by other supervisory personnel directly responsible for the worker's performance, and the complete report should be reviewed and signed by the employee involved. A copy of this report should be given the worker, and one copy filed in his personal record.

F. PERSONNEL RECORDS

A confidential personnel record which is available only to authorized persons will be maintained for each member of the staff. Information in this record includes:

1. Employment application and references
2. Medical records
3. Appointment papers and revisions
4. Evaluation reports
5. Record of training received

G. PROFESSIONAL ORGANIZATIONS

All staff members should be encouraged to maintain professional affiliations which are relevant to their responsibilities in the facility. Regardless of whether membership is maintained in these groups, the facility should subscribe to the professional publications they maintain and make them available to the total staff.

1. NASWHP

The facility will find membership in the National Association of Sheltered Workshops and Homebound Programs, and state and local chapters of this organization, very helpful in keeping abreast of current developments in the field.

2. NRA

The National Rehabilitation Association with its sub-groups for the rehabilitation counselor (NRCA—National Rehabilitation Counselor's Association) and vocational evaluator (VEWAA—Vocational Evaluation and Work Adjustment Association) also offer programs which are vital to professional growth. This organization on the state level is known as FRA (Florida Rehabilitation Association).

3. APGA

The American Personnel and Guidance Association with its subgroup for rehabilitation counselors (ARCA—American Rehabilitation Counselors Association) should be considered.

4. AVA

The American Vocational Association and Florida Vocational Association are other associations which should be considered.

5. EPH Committees

The facility should cooperate as much as possible with the President's and Governor's Committees for Employment of the Physically Handicapped. Also, it should be represented on local EPH committees.

6. Others

Some of the other relevant organizations are the NEA and FEA (National Educational Association and Florida Educational Association), and FAEA (Florida Adult Educational Association).

H. STANDARDS

1. Rationale for Standards

There is widespread interest in standards for facilities. Much of this interest may be attributed to the fact that substantial amounts of money are channeled to facilities through community support, the purchase of services, and government grants. Contributors and consumers of services want to know whether funds are being expended effectively. Standards provide the means for making such a determination. Standards are intended to be a device to assure quality and should be used as an educational tool. They will help the governing board of the facility and other interested groups in the community to better understand what is required for a sound program. They will also serve as a means of self-evaluation for the board, administrator, and staff.

2. Background

Standards have been developed in recent years by the National Policy and Performance Council, National Association of Sheltered Workshops and Homebound Programs, Association of Rehabilitation Centers, Goodwill Industries of America, the Commission on Accreditation of Rehabilitation Facilities, and National Industries for the Blind. Materials for this guide have been drawn from all these sources with primary emphasis given to the National Policy and Performance Council standards. These standards were adopted by the Social and Rehabilitation Services Administration in 1967 for primary use in conducting grant programs for training services and workshop improvement (Section 13a and 13b of Public Law 89-333), and they have been published in Standards for Rehabilitation Facilities and Sheltered Workshops. A copy of this manual may be obtained from the Rehabilitation Facilities Section, Florida Division of Vocational Rehabilitation, State Department of Education, Tallahassee, Florida, 32304. Individual planning groups may wish to consult other standards for special emphasis.

3. Voluntary Accreditation

Voluntary accreditation is offered by the Commission on Accreditation of Rehabilitation Facilities and the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped. Increasingly, state rehabilitation agencies are being encouraged to use accredited work-oriented facilities. Once a facility program is in operation, an appropriate accreditation plan should be selected and maintained.

4. Implementation

It is recommended that the SRS (Social and Rehabilitation Services) standards be used in conjunction with this guide to formulate the specific objectives for a local work-oriented facility. The criteria and recommended practices should be considered the minimum objectives, and any deviations should be accompanied by a thorough and adequate justification. In situations where compromise must be considered, recognition should be made of the fact that the immediate concern will be only partially solved by lowering standards. Provision of ideal services will be approximated only if services are built on an ideal base.

CHAPTER V

PHYSICAL PLANT FOR THE WORK-ORIENTED FACILITY

A. IMPORTANCE OF THE PHYSICAL PLANT

Both the exterior and interior structure of the physical facility should be appropriate for the program of services to be provided. The building committee should keep in mind that "anything is **not** better than nothing" and that the building itself is one factor in selling the facility to the public. Several aspects which should be considered in the selection of the physical plant are discussed below.

B. LOCATION

In too many cases, the work-oriented facility has been developed in an unsuitable location. This is true primarily because of the need to trim costs. Bargain property and donated land or buildings are often far from being real bargains. The land that is in the wrong place cannot possibly serve the purpose for which a work-oriented facility is intended. Prior to the selection of a building, city ordinances should be examined. Other considerations in selecting property are:

1. Accessibility

The facility should be located in an area accessible to clients, the professional staff, and volunteer workers. Such questions as the increasing or decreasing value of property, community plans for urban renewal, housing developments, and freeways should be considered. Sidewalks should link pedestrian entrances to bus stops and nearby parking areas. Roadways should be adequately designed for easy maneuvering of vehicles. One can readily see that the total program within a work-oriented facility is dependent entirely upon clients, staff, and community support. Therefore, any building should be easily accessible to the entire community and located in a section of the community that any citizen would be proud to visit. Other accessibility considerations include:

a. Whether streets or roads are under county or state jurisdiction
b. Delivery services within reasonable distance
c. Adequate fire and police protection

d. Adequate parking space for staff and clientele (either on site or nearby)

e. Location convenient to customers if a product is to be sold directly

2. Transportation

Many facilities have failed from lack of utilization because transportation to them was not available. Facility-operated transportation for clients becomes a tiring task and is usually undesirable. A work-oriented facility should be on a "beaten path" so that it may be seen frequently by members of the community, customers, and all interested individuals. There should be sufficient parking space for clients, staff members, visitors, and for trucks and other delivery vehicles.

C. CONSTRUCTION AND DESIGN

A new building planned and constructed specifically as a work-oriented facility is the ideal. Many times this is not possible, however, and existing buildings must be remodeled or altered to make them suitable. In either the selection or construction of the building, the committee should be mindful of the following:

1. Appearance

A work-oriented facility should resemble a place of business or industry.

2. Shipping and Receiving Area

Loading docks should be planned in proper locations for efficient shipping and receiving.

3. Storage

Approximately twenty percent of the facility space should be used as storage or warehouse area and should be located between the receiving station and the work area. This will minimize excessive handling of materials.

4. Work Area

The work area should be flexible with as much open space as possible so that it may be changed, depending upon the specific contractual work being performed. Every immovable wall within the work-oriented facility will in some way limit the usable space. Work areas should have high ceilings and as few columns as possible.

5. Floor

The floor should be sturdy enough to hold heavy equipment and storage materials. Consideration should be given to the flooring's resilience, water and oil resistance, cleaning required, durability, and maintenance cost.

6. Walls

Walls should be planned in light of acoustic properties, moisture resistance, fire rating, and flexibility (demountable where feasible).

7. Permit Restrictions

In the case of new construction, most cities require building permits which may impose certain restrictions upon the construction and design of the building.

8. Floor Space

There should be 150 square feet of floor space per client to be served in the work-oriented facility.

9. Heating and Cooling

A proper heating, air conditioning, and ventilation system should be developed for the entire facility.

D. FUNCTIONAL ASPECTS OF THE BUILDING

In order to make the physical plant as functional as possible, the overall purposes of the facility must be weighed heavily. One of the major aspects of making the building functional is to design or remodel it so that it is accessible to and usable by physically handicapped persons. Some of the provisions required are the safety features and the special architectural features mentioned below.

1. Safety Features

All clients of the facility will be mentally or physically handicapped. Therefore, safety features of the physical plant are of utmost importance. Safety within the facility is the direct responsibility of the director. Workmen's Compensation and insurance rates may be changed as a result of poor safety records. The following safety measures should be considered as a bare minimum:

a. Regularly scheduled safety training programs
b. Clean, neat, uncluttered, and well-marked aisle space
c. Properly installed safety devices, machines, and equipment
d. An orderly and well-organized floor plan
e. Electrical outlets and fixtures located on the wall or overhead
f. Proper storage of materials which increase hazards through combustion or falling
g. A first-aid program and an emergency medical services arrangement
h. Fire alarms which can easily be seen, heard, or felt by clients

2. Special Features for the Handicapped

a. **Dining Area** — There should be a dining area large enough for use by both clients and staff. An appropriate number of tables the proper height for persons confined to wheelchairs should be provided.

b. **Toilet Facilities** — There must be adequate toilet facilities with provisions for handicapped people. Every restroom should have at least one open, wide booth with hand rails at the sides of the commode. Other special features should include suspended lavatories and mirrors on swivel axes for wheelchair clients.

c. **Bars and Rails** — Appropriate locations and designs for grab bars and hand rails should be considered. Bars or rails should be placed in such places as steps or stairs, in elevators, and along corridors.

d. **Corridors, Doors, Thresholds** — All corridors should be at least six feet wide, and all interior doors should be at least thirty-two inches wide in order to accommodate wheelchairs. Doors should be easy to open; swinging doors made of glass or some other transparent material are preferable. At least one street-level entrance wide enough for wheelchairs should be provided. There should be no thresholds.

e. **Ramps, Steps, Stairs** — Ramps should be provided at all elevated walkways and entrances; however, some steps or stairs may be necessary. If so, stair risers should be of uniform height (no more than seven inches) throughout the building.

f. **Drinking Fountains** — Drinking fountains should be accessible to wheelchair clients. Usually regular drinking fountains can be used by mounting appropriate cup holders and providing cups.

g. **Multi-Story Building Provisions** — Ground level, single-story buildings are ideal when possible. If the physical plant must have more than one story, adequate elevators and dollies must be provided. Elevators in multi-story buildings should be self-leveling and large enough to serve several wheelchair clients at one time.

E. EQUIPMENT, FURNITURE AND SUPPLIES

The equipment, office furniture, and supplies needed will depend upon contracts obtained, the program of services to be offered, and the staff to be employed. There are various standard lists of equipment which have been provided for work-oriented facilities throughout the country. For consultation on the type of equipment and furnishings necessary, contact the state Vocational Rehabilitation agency.

CHAPTER VI

SUMMARY

The material included in this publication has gone considerably beyond the standards in many instances in an attempt to inspire interested groups to provide "ideal" services rather than minimum standard services. Even the recommendations for ideal services should not be considered an end in themselves. Concepts and practices in rehabilitation are changing rapidly and will necessitate revisions in standards frequently to reflect sound, up-to-date practices. Provisions must be made in all plans to keep abreast of these changes and incorporate them quickly and effectively.

Ideal Services can be accomplished only through careful planning. Quality services can continue only through community support, and the community is willing to support only quality programs. Therefore, it is of the utmost importance that the total community be informed of and involved in the facility program.

The services of the facility as they relate to the needs of the community must be continually evaluated. Community needs change almost daily; therefore, facility services must be flexible and ready for any alterations necessary to serve its community. The board of the work-oriented facility should be mindful that the facility is capable of offering more diversified services than most other service programs. Therefore, constant communications with representatives of other community services should be maintained in an effort to determine the facility's role in future needed services.

By following the suggestions as outlined in this publication, a facility may be developed which every member of the community can look upon with pride. And if the community is proud of its facility, the employers of the community will be proud to hire its product — the handicapped.

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APPENDIX

SUGGESTED CONSTITUTION AND BY-LAWS FOR A WORKSHOP FOR THE HANDICAPPED

This constitution is not offered as a model to be used without revision, but does suggest important items of information to be considered.

CONSTITUTION AND BY-LAWS OF

____

(Name of Workshop)

Adopted ____________________

(date)

Article I

Name

The name of this Agency shall be ____________________ and it shall be located in ______________, ______________, ______________.

(city) (county) (state)

Article II

Management

Section 1 MANAGEMENT. The management and control of the affairs of the Agency shall be vested in and exercised by a Board of Directors consisting of not more than twenty-four nor less than fifteen persons, who shall be elected, upon the organization of the corporation (Agency), by the incorporators thereof.

Section 2 ELECTION OF BOARD. The first Board of Directors shall serve until the first annual meeting of the corporation and until their respective successors are elected and qualified. At the first annual meeting, the Board shall be divided into three groups, as nearly divisible by three as possible, one group with a term of one year, the second group with a term expiring in two years, and the third group with a term expiring in three years; at all annual elections thereafter, the directors for each group shall be elected by the Board of Directors for a term of three years to succeed the directors whose terms then expire. No director shall be eligible for re-election except:

a. Where at least a year has elapsed since termination of his previous term;

b. Where the director has been elected to fill an unexpired term;

c. Where at any annual meeting it shall be determined that in special cases a director shall be eligible to succeed himself.

Section 3 BOARD VACANCY. A vacancy on the Board of Directors shall be filled by election by the majority of the remaining directors present at any annual meeting of the Board, or at any regular or special meeting, provided that notice of the proposed election of a director to fill such vacancy is given in the notice of such regular or special meeting. Each person so appointed to fill a vacancy shall serve the unexpired term.

Section 4 BOARD OF MEETINGS. The Board of Directors shall meet approximately once a month at a time and place designated by the President, except that no regular meeting shall be held during the months of July and August. Special meeting of the Board of Directors shall be called upon the written request of six (6) members of the Board, or may be called at the discretion of the President. Notice of the Annual Meeting shall be published at least ten (10) days prior thereto. Written notice of any regular meeting of the Board of Directors shall be sent to each member of the Board at least five (5) days prior thereto, and written notice of any special meetings shall be sent to each member of the Board at least five (5) days prior thereto.

Section 5 ANNUAL MEETING. The Annual Meeting of the agency shall be held during the month of ________________ of each year at a time and place to be designated by the President.

Section 6 NOTICES. The Secretary of the Agency shall prepare and cause to be sent or published all notices herein mentioned.

Section 7 QUORUM. A quorum at any regular or special meeting shall consist of not less than one-third of the Directors then in office.

Section 8 VOTING. All matters considered at a meeting shall be decided by a majority vote of those present, and all votes shall be by voice, except that upon request of anyone present a roll call vote shall be taken. The President shall not vote except in case of tie, in which event he shall cast the deciding vote.

Article III

Officers

Section 1 OFFICERS. The officers of this Agency shall be a President, a Vice-President, Secretary, Treasurer and such other officers as the Board of Directors may from time to time determine.

Section 2 ELECTION OF OFFICERS. A majority of the whole Board of Directors, at each Annual Meeting, shall choose a President, a Vice-President, Secretary and Treasurer. The officers of the Agency shall hold office for a term of one year and until their successors are chosen and qualify in their stead.

Section 3 DUTIES. The officers of the Agency shall perform such duties as may be required of them by the Board of Directors.

Article IV

Standing Committees

Except as hereinafter otherwise provided, the following Standing Committees, which shall from time to time make written or oral reports of their activities, shall be appointed for a term of one (1) year by the President as soon as feasible after his election and his induction, and their personnel shall be reported to the Board of Directors at or before the next ensuing meeting.

EXECUTIVE COMMITTEE: The elected officers, together with the Chairmen of the other Standing Committees, shall constitute the Executive Committee. The Executive Committee shall be fully empowered to exercise all the functions of the Board of Directors betwen meetings, subject, however, to the approval of the Board of Directors, but provided that its action in administrative matters shall not be subject to such approval. The majority of the Executive Committee shall constitute a quorum.

PUBLIC RELATIONS COMMITTEE: The function of the Committee shall be to plan and carry out an appropriate program of publicity designed to inform and interpret the activities of the Agency.

PLACEMENT COMMITTEE: The function of the Committee shall be to plan and carry out an appropriate program designed to implement the placement activities of the Agency.

NOMINATING COMMITTEE: This Committee shall be composed of not less than three (3) Directors and shall be appointed annually by the President, subject to the approval of the Board of Directors. It shall propose for nomination names of individuals to fill vacancies on the Board of Directors and for the various offices of the Agency, and shall file with the Secretary its report together with its list of nominees not less than ten (10) days prior to the annual election. The Secretary shall forthwith mail notice of the same to all Directors of the Agency.

Article V

Executive Director

The operating head of the Agency shall be designated as the Executive Director. He shall be employed by the Agency for such term as the Board of Directors may determine.

Article VI

Funds and Securities

Section 1 The Board of Directors may authorize any officer or officers, or any employee in conjunction with one or more officers, in the name of and on behalf of the corporation to enter into any contract or execute and deliver any instrument or to sign checks, drafts or other orders for payment of money or notes or other evidence of indebtedness, and such authority may be general or it may be confined to specific instances; and unless so authorized by the Board of Directors, no officer shall have the power or authority to bind the corporation by any contract or engagement, to pledge its credit, or to render it financially liable for any purpose or in any amount.

Section 2 All funds of the Agency not otherwise employed shall be deposited from time to time to the credit of the Agency in such banks, trust companies or other depositories as the Board of Directors may select or as may be selected by any office or officers of the Agency to whom such power may from time to time be delegated by the Board of Directors; and for the purpose of such deposit, the officer and/or officers to whom such power may be delegated by the Board of Directors, may endorse, sign and deliver checks, drafts, and other orders for the payment of money to the order of the corporation.

Article VII

Fiscal Year

The fiscal year shall begin on the first day of January in each year.

Article VIII

Amendments

This Constitution and Bylaws may be altered or amended by a two-thirds (2/3) vote of the Directors present at any regular meeting of the Board, notice of which proposed amendment or amendments has been given to the Board of Directors along with notice of the meeting itself.*

**Sheltered Workshops — A Handbook Revised* 1966 — National Association of Sheltered Workshops and Homebound Programs — 1522 K Street, N. W. Washington, D.C. 20005

ED039317

REHABILITATION SERVICES FOR THE BLIND AND VISUALLY IMPAIRED

IDEAL SERVICES SERIES

VOLUME V

BY

EUGENE D. MORGRET

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL OFFICE OF EDUCATION POSITION OR POLICY.

STATE DEPARTMENT OF EDUCATION
Division of Vocational Rehabilitation
Rehabilitation Facilities Section

In Affiliation With
FLORIDA COUNCIL FOR THE BLIND
Tallahassee, Florida
June, 1968

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FOREWORD

In 1965 federal legislation was enacted which enabled each state to conduct a Workshops and Rehabilitation Facilities Planning Project in an effort to bring about more adequate rehabilitation services for the handicapped. Such a project was initiated in Florida in July 1966, by the Division of Vocational Rehabilitation, State Department of Education, and the Florida Council for the Blind. One of the objectives of this project was to provide community leaders with various materials to assist them in planning for development and expansion of local facilities. Consequently, the Ideal Services Series was instituted to present basic materials about ideal rehabilitation services and facilities.

Much has been written in the last few years concerning the philosophy of services for the blind and the visually impaired. Rehabilitation services for the blind have received increasing attention as the potentials of the blind and the severely visually handicapped are made evident by their successful entry into the labor market. In order to develop these potentials to the fullest however, a wide range of special services is needed.

This guide is presented for the purpose of outlining the ideal services to be provided for the blind and visually handicapped in their community.

The suggestions for facilities and workshops are based on the regulations found in *Standards for Rehabilitation Facilities and Sheltered Workshops, 1967.*[1] However, it is recommended that the facilities also conform to the standards of the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped, 84 5th Avenue, New York City, New York, 10011.

Murdock Martin, Executive Director
Florida Council for the Blind

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[1] Vocational Rehabilitation Administration, *Standards for Rehabilitation Facilities and Sheltered Workshops,* 1967 (Washington, D.C.,: Department of Health, Education and Welfare, 1967).

ABOUT THE AUTHOR

Eugene D. Morgret grew up and completed high school in the state of Pennsylvania. He worked for several years as a door-to-door salesman and then became sales manager of the Pittsburgh branch of the Pennsylvania Association for the Blind. He served in that capacity from 1927 to 1940, and then was sales manager of the Pennsylvania Association for the Blind for a short time.

Mr. Morgret made a number of contributions to the legislative program for the handicapped in Pennsylvania, and he assisted a nationwide group in obtaining passage of the Wagner O'Day Act in 1938. He was instrumental in the establishment of National Industries for the Blind in 1939, and in 1941 he began working for this organization as sales manager. In 1943, Mr. Morgret was promoted to the position of Assistant General Manager, and he served in that capacity until his retirement in 1963. Since retiring, he has worked as a consultant for a number of local and state-wide agencies for the blind to assist them in planning better services for the blind and visually impaired.

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CHAPTER I
INTRODUCTION

A. WHO ARE THE BLIND AND VISUALLY IMPAIRED?

Two definitions of blindness and visual impairment must be used in considering rehabilitation services for this disability group. First is the legal definition, which must be used in the case of a work-oriented facility in which handicapped persons perform work for the government. In such a facility the articles produced are identified as being made by the blind, and therefore a visually handicapped person whose vision exceeds the legal definition of blindness must be listed on the payroll as a sighted employee.[1]

1. Definition of the Legally Blind

The word "blind" refers to a person whose visual acuity with correcting lens does not exceed 20/200 in the better eye, or a person whose visual acuity is greater than this but with a limited field of vision so that the wide diameter of the visual field subtends and angles no more than 20 degrees (Federal Statutes, Title 41, Section 51 - 1.1; Florida Statutes, Chapter 413, Section 413.021-1).

2. Definition of Visual Impairment

A visually impaired person, or one who is not legally blind, is an individual whose visual acuity is such that he either cannot continue his regular work or would be handicapped in obtaining any kind of work in industry. This definition is used for many purposes and is generally more applicable in dealing with the needs of the visually handicapped.

B. SOME OF THE CAUSES OF BLINDNESS AND VISUAL IMPAIRMENTS

Despite recent medical advances. the prevalence of blindness and visual impairment is increasing.[2] Visual failure often cannot be explained, and there are a great number of diseases or conditions known to be common underlying factors. Only a few of these diseases or conditions are listed here.

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[1] The "Schedule of Blind-Made Products" gives the percentages of sighted persons who can be used in helping the blind produce items for the Federal Government. This schedule may be obtained from the committee on Purchases of Blind-Made Products, 1511 K Street, N.W., Washington, D. C. 20005.

[2] American Association of Workers for the Blind, Inc., *Blindness* (Washington, D. C.: American Association of Workers for the Blind, Inc., 1965), p. 59.

1. **Glaucoma**

This is a condition of increased pressure in the eye which results in tissue damage. Its effects are irreversible but usually could have been prevented by early detection and care.

2. **Amblyopia**

Amblyopia is the result of an early disease. This disease leaves one eye significantly different from the other in refractive ability. It is irreversible if not treated early.

3. **Corneal Diseases**

Corneal diseases are one of the leading causes of blindness. The cornea loses its transparency due to malnutrition or improper medical care of corneal infections.

4. **Cataracts**

Cataracts are the leading cause of blindness.[1] They may be caused by any number of problems resulting in the crystalline lens becoming opaque. These can sometimes be removed surgically and compensated for by glasses or contact lenses.

5. **Retinal Diseases**

Retinal diseases or impairments are most frequently caused by diabetes. Some of these diseases or impairments can be treated with fair success in their early stages.

6. **Myopia**

Myopia, or nearsightedness, is common but severe cases of it can lead to blindness. At the present time no way is known to prevent or improve myopia, but considerable research is being done in this area.

7. **Uveitis**

Uveitis is inflammation of the uveal tract, which consists of the pigmented iris, ciliary body, and choroid. If the inflamed tract of one eye does not respond to drugs, surgical removal is frequently advisable in order to protect the other eye.

8. **Other Causes**

There are many other causes of blindness and visual impairment, some of which are specifically identified and others which remain more obscure. Some of these causes can probably be prevented and an increasing number of them treated successfully as medical science progresses in understanding the human eye. Considerable research is underway, but thus far the advances made have been relatively unimpressive.[2]

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[1] National Society for the Prevention of Blindness, Inc., *Estimated Statistics on Blindness and Visual Problems.* (New York: National Society for the Prevention of Blindness), pp. 46-47.

[2] *Ibid.*, pp. 60-72.

C. THE BLIND AND VISUALLY HANDICAPPED TO BE SERVED

There is a wide range of blind and visually handicapped persons who need rehabilitation services. Much can be done with children to prevent further eye damage and to help them adjust to whatever visual handicaps they may have. Adolescents need vocational counseling, testing, training, and perhaps other vocational services. Adults need rehabilitative services when their visual handicap might respond to treatment of surgery and when they need special training, sheltered employment, homebound employment, or help in finding employment. Even many of the elderly can benefit from such services as these.

D. SERVICES NEEDED BY THE BLIND AND VISUALLY HANDICAPPED

1. Referral Services
2. Screening and Detection Services
3. Registry and Planning Services
4. Medical and Surgical Services
5. Mobile Eye Clinic Services
6. Psychological Services
7. Social Services
8. Educational Services
9. Vocational Services
10. Prosthetic Devices and Visual Aids
11. Recreational Services

F. OUTLINE OF THIS GUIDE

The purpose of this guide is to aid community leaders in identifying the rehabilitation services needed by the blind and visually impaired. The first chapter indicates who the "blind" and "visually impaired" are and what services they need. The second chapter is geared toward showing how various persons, facilities, and agencies within the community can best serve the blind, and the third chapter describes a comprehensive work-oriented facility for the blind. Of course, no community can suddenly add all of these services, but it can develop them over a period of time, gradually working toward the ideal. It is not practical for every community to establish a comprehensive facility for the blind. However, Chapter III will help professional persons in communities without a work-oriented facility for the blind to better understand the services offered by such a facility and how they can best utilize the regional facility to which they have access.

CHAPTER II
VARIOUS TYPES OF FACILITIES, SERVICES AND AGENCIES FOUND IN THE IDEAL COMMUNITY

A. THE THERAPEUTIC COMMUNITY

There are many services in the community which are not designed specifically for the blind, but from which the blind and visually impaired can benefit. They may benefit from one or more of these individual services, but they also benefit from the total community milieu (TCM). The TCM consists of all the facilities, attitudes, and opportunities of the community, because all of these contribute to making the life of the handicapped person as healthy, happy, and normal as possible.

B. IDEAL SERVICES AND FACILITIES

The services needed by the blind and visually impaired are mentioned in this chapter, and some of these are discussed in detail in order to demonstrate how this disability group "fits" into the community environment, contributing to and drawing from the community. Perhaps no community could provide all the services mentioned, but its ultimate goal should be either to provide them or to obtain them elsewhere.

1. Referral, Registry, and Planning Program

Persons in need of services often do not know where to go for them or may not even be aware that the services are available. Referrals may be made by various service agencies, schools, churches, and professional workers. A registry of its blind and visually impaired citizens enables community leaders to know how many persons need certain types of services so that planning programs can be more realistic and appropriate.

2. Medical, Nursing, and Related Services

a. **Physicians** — Most physicians serve the blind and visually impaired in much the same way they would serve persons with normal vision. The physicians who are specifically helpful to this disability group are the ophthalmologist and surgeon. The ophthalmologist is skilled in diagnosing and treating eye-related problems, and the surgeon is skilled in correcting them through surgery when possible. Any physician can be of greater help to the visually impaired individual and to professional persons working with the blind if he is rehabilitation-oriented and takes the patient's employment potential into consideration.

b. **Special Clinics**

(1) **Types** — There are several types of clinics related to

vision. Among these are eye clinics, low vision clinics, screening programs, and glaucoma clinics. One or more of these clinics are frequently provided by local Lions Clubs or other service clubs, but if they are not available through some club or organization, the Department of Public Health might plan for these kinds of services. The equipment needed would depend on the scope of work of a particular clinic, and in any case the equipment should be prescribed by an ophthalmologist who will serve as a consultant for the clinic staff.

(2) **Mobile Eye Clinic** — The purpose of the mobile eye clinic is to render screening and detection services and to serve as a referral source. Such a clinic should have an ophthalmologist on a consultative basis. The traveling personnel should include at least two trained persons who may be either full-time or part-time, depending on the clinic's schedule. The mobile clinic serves sparsely inhabited areas and small towns on regularly scheduled dates. Such a unit might be sponsored by the Florida Council for the Blind, the Public Health Service, or other agencies or organizations.

c. **Screening and Detection Programs** — In some cases eye damage can be corrected or further injury prevented by taking certain precautions and treatment measures. Such measures are generally more effective in the earlier stages of a disease or handicapping condition, and therefore early detection is important. Screening and detection programs in schools are particularly helpful in screening children who need special attention due to visual problems. The county school boards in various districts have health nurses who should be trained to make periodic tests of children's vision and determine if they need corrective lenses or further diagnosis. Most schools presently have this service but need to expand it and provide special professional training for the nurses in order to insure quality screening and early detection.

d. **Prosthetic Devices and Visual Aids** — The ophthalmologist or some other eye specialist may recommend glasses, contact lenses, an artificial eye, a "patch" to cover one eye, or other prostheses related to vision. Businesses which handle these prostheses should be available within reasonable proximity. Prosthetic services should not end with supplying a client with a prosthesis or visual aid, but should include instruction in proper use and care of the device and follow-up services.

3. **Psychological Services**

The blind and visually impaired may benefit from psychological services in much the same way as any other person. The blind individual is likely to have a great deal of emotional feelings through which he must work. In administering tests to this disability group, the psychologist may have to use slight modifications. A psychologist dealing with blind persons can be most helpful if he is rehabilitation-oriented and experienced in interpreting tests in light of vocational implications.

4. **Social Services**

Social services are usually rendered by social workers employed by some agency. The blind and visually impaired may possibly need these services more frequently and in greater depth than most citizens. Some of the more specialized social services which should be available in the community are discussed below.

a. **Individual Counseling on Personal Problems** — Personal counseling may be available through guidance centers, visiting social workers, Public Health nurses, physicians and ministers. Adolescents have access to such counseling in school, where a person trained in guidance and counseling is usually available. This type of service may be particularly useful to blind or severely visually-impaired youth, helping them to accept and cope with their handicap in a healthy manner.

b. **Group Counseling** — Group counseling is provided by some workshop and rehabilitation facilities. More frequently, however, it is available through mental health associations, local hospitals and clinics, and family service agencies. It may be especially helpful for newly blinded persons, enabling them to understand how other persons have accepted their blindness without hostility and have learned to live a normal life.

c. **Marriage and Family Counseling** — Marriage counseling is available through trained marriage counselors and some physicians and ministers. Family counseling may be obtained through family service agencies, social workers employed by various agencies, or ministers. Such counseling may deal with parent-child relationship problems, financial difficulties, budgeting, ways of dealing with family crises, and family planning. Blind persons may not need these services any more frequently than others do.

5. **Occupational Therapy**

This service is usually rendered by medically-oriented or work-oriented facilities such as hospitals, Easter Seal Clinics, or Goodwill Industries.

6. **Recreational Services**

a. **Value of Recreation** — Recreation has been defined as play or mode of diversion. Recreational services in any rehabilitation program reflect both of these. Recreation helps remove feelings of loneliness which the blind, and particularly the newly blinded, sometimes develop. It often enables an individual to adjust better to his disability, work, and living arrangements than he would be able to otherwise.

b. **Types of Recreational Programs** — The recreational program in any community should provide opportunities for all persons of every age group, including the blind and visually handicapped. In some communities arrangements must be made for the blind to use regular facilities at certain times and under the supervision of volunteers. Such facilities may include YMCA and YWCA centers, community centers, and public parks, swimming pools, and children's playgrounds. If no agency for the blind exists in a community, and no funds are available, service organizations or church groups should be encouraged to sponsor recreational programs for the blind. Volunteer personnel could organize and direct such a program for one or two days (or evenings) per week. If the community has a paid person in charge of recreation, he should be encouraged to plan programs for the handicapped or to assist volunteers with their planning.

c. **Types of Activities** — The types of activities appropriate for some blind persons are more limited than those for individuals with other disabilities but nevertheless include a variety of activities. Some of the games and other activities which the blind usually enjoy are reading (reading Braille, or being read to), card games, bingo, picnics, movies, lectures, gardening, operating ham radios, musical programs, skating, fishing, bowling, boating, tobogganing, golfing, camping, horseback riding, wrestling, etc. In the case of sports, the blind must often be spectators rather than participants; nevertheless, there are quite a number of sports in which the blind can actively participate. A few of these activities call for special equipment or modifications. For instance, cards and board games should be in Braille.[1] To run track, a blind person needs a wire with a loop on it to serve as a guide; and a bar guide is very helpful in bowling.

7. Educational Services

Most of the educational services available to the blind and visually impaired are provided by the State Council for the Blind, residential schools, special classes in public schools, and rehabilitation centers for the blind. However, community volunteers can also help in a number of ways.

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[1] Information on special recreational equipment for the blind can be obtained from the American Foundation for the Blind, 15 West 16th Street, New York City, New York 10011.

a. **Communication Skills** — Certain communication skills are essential for the blind person to pursue a good education. These are usually taught along with appropriate remedial instruction. They include:

(1) Reading both text and written Braille, and learning to write Braille with the slate and stylus or Braille writer.

(2) Use of the tape recorder, transcriber, record player, various optical aids, abacus, circular slide rule, cube writer, arithmetic slate, etc.

(3) Remedial instruction in basic areas such as reading and spelling.

(4) Mental arithmetic computations.

(5) Typing.

(6) Use of the typewriter-like instrument which raises Braille figures for the blind person to find.

b. **School Classes** — The blind and visually impaired may be placed in one of three types of classroom situations. The ideal class is a special class for the blind and visually impaired in a regular public school. The second alternative is to send them to a residential school. The least desirable situation is to place them in classes with sighted students, unless he has mastered various communication skills and proves himself capable of performing well in these classes.

(1) **Special Classes for the Blind in Public Schools** — Some public school systems in more heavily populated areas provide special classes for the blind visually impaired. These classes are taught by persons trained in the same teaching methods employed in regular classes. Special equipment and materials such as large-type typewriters, Braille books and writing equipment, recorders, clear-type (large type) textbooks, etc., are available. This kind of class serves as a referral source of students to the Florida Council for the Blind. Any community with enough blind and visually impaired students to justify a special class should contact the director of special education in the local school system; the Florida Council for the Blind; or the Florida Society for the Prevention of Blindness, which is located in Tampa.

(2) **Residential School for the Blind** — Residential schools for the blind extend from kindergarten through

high school. The curriculum is similar to that of any school, but in addition there is an emphasis on classes in such areas as music and "shop," and there is a well-developed recreational program. These schools are particularly beneficial to blind and visually impaired youth who live in rural areas where opportunities are very limited. A counselor from the Florida Council for the Blind should work with the students.

(3) **Regular Classes** — Once the necessary communication skills have been mastered, some blind persons can manage quite adequately in public school, college classes, or a business or vocational school. The state provides them with records or "talking books," a record player, and other equipment which is essential for them to perform well in their classes. Also, persons may sometimes be paid to assist the blind with their studies.

c. **Home Teaching Service** — This service is now available through the State Council for the Blind and is designed to provide training for those who will not or cannot go to a vocational rehabilitation center. Instruction is given in practical aspects of home living such as sewing, cooking, using hand tools, and moving about the house. Also, limited instruction may be given in the communication skills and use of equipment discussed above.

d. **Volunteer Projects** — Community volunteer groups may tutor blind or visually impaired children attending local public schools; read to blind persons, particularly magazines and newspaper articles; make tape recordings of books for blind students; and learn Braille in order to transcribe material to Braille if it is not already available. These projects can contribute a great deal to both formal and informal education of the visually handicapped.

e. **Mobility Training** — Unless he is able to move about without constant assistance from others, the blind individual will be extremely limited; therefore, mobility instruction is one of the most important aspects of his training. This instruction usually requires a considerable amount of time and is done on an individual basis. The method usually taught is the Hoover method or "touch technique," in which the blind person feels his way about by means of a long cane.[1]

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[1] Edwin G. Christensen, *Adjustment and Pre-Vocational Training Program for Adult Blind and Partially Seeing.* (Grand Forks, North Dakota: North Dakota Division of Vocational Administration, 1966), p. 19.

f. **Training in Activities of Daily Living** — Blind persons require special training in performing many of the activities of daily living. These activities include personal hygiene and grooming, selecting their clothes, identifying clothes which match and can be worn together, doing their laundry, table etiquette and other social graces, sweeping and dusting, making the bed, identifying coins and remembering how much money they have, etc. The blind often tend to develop nervous habits, and these habits are pointed out to them in training programs for activities of daily living. They are taught how to determine the location and rate of approaching automobiles and to face persons with whom they are conversing.[1]

8. Services for the Deaf-Blind

On October 3, 1967, the President signed a bill providing for the establishment of the National Center for Deaf-Blind Youth and Adults. National Center is to be in operation by July 1, 1968. It will provide consultation, treatment, and residential services for the deaf-blind. A complete range of rehabilitation services are available to the blind through the Industrial Home for the Blind (57 Willoughby Street, Brooklyn, New York, New York 11201). The Anne Sullivan Macy Services for Deaf-Blind Persons (147-16 Archer Avenue, Jamaica, New York 11435) serves a few clients from other states, although it is designed primarily for New York residents. Educational services for the deaf-blind are provided by Perkins School for the Blind (Watertown, Massachusetts 02172) and Alabama Institute for the Deaf and Blind (South Street, P.O. Box 268, Talladega, Alabama 35160).

9. Vocational Services

Because of the basic importance of work in the life of an individual and the severe work handicap of the visually impaired and the blind, it is very important for this group to have access to a full range of vocational services. This area is so significant that Chapter III will be devoted to it.

10. Multi-Disability Rehabilitation Facilities

The majority of communities do not have a sufficient number of visually handicapped individuals or persons with other types of handicaps to merit a special facility to serve each of these disabilities separately. In the case of medically-oriented facilities such as hospitals and Easter Seal Centers, this arrangement is usually satisfactory; but in the case of work-oriented facilities it is almost always unsatisfactory. In a work situation the blind are more limited than other persons in the tasks they are capable of performing, and they usually work at a slower pace. They need closer supervision and a work area with safety equipment designed especially for the blind. Nevertheless, the services of any organization serving the disabled should be solicited and used in areas where services for the blind are not available and cannot be anticipated in the near future. This is particularly true where there are less than thirty employable blind people who could utilize a local work-oriented facility. However, if a blind person in a less populated area is placed in a multi-disability work-oriented facility, the vocational counselor should determine that the appropriate kinds of personnel and facilities are available. A multi-disability facility attempting to serve the blind must have a special philosophy toward the blind as well as staff members who are experienced in working with the blind.

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[1] *Ibid*, p. 21.

C. AGENCIES

1. Florida Council for the Blind

a. Eligibility

(1) **Children** — Services are offered to children through the Council for the Blind if they are blind or in danger of blindness or have an eye pathology, muscle imbalance or other serious visual difficulty.

(2) **Adults** — Persons over sixteen years old are eligible if they are legally blind (corrected vision of no better than 20/200 in the better eye), are in danger of severe loss in both eyes, have cataracts, or have operable glaucoma.

b. **Services Available** — Some of the services listed below are provided only in cases of financial need, while others are available to any person who meets the eligibility requirements.

(1) **Children** — Services for children include eye diagnosis, medication, treatment, surgery, hospitalization, pre- and post- operative glasses, artificial eyes, transportation, counseling for parents, consultation, demonstration of educational tools, Talking Book service, and home teaching.

(2) **Adults** — Adults who are unemployable may receive the same services as those listed for children, except that counseling is available to the client himself rather than his parents. Rehabilitable adults (usually between sixteen and sixty-five) may receive visual diagnosis, a general physical examination, physical restoration, and hospitalization. Vocational counseling, work evaluation, personal adjustment training, Rehabilitation Center attendance, vocational training, job counseling and placement, and

maintenance during the time of training or treatment are offered when indicated.

2. **Division of Vocational Rehabilitation, Florida Department of Education**

a. Eligibility — Vocational Rehabilitation services are available to persons of employable age or approaching that age who seem to have the potential for employment. Individuals who are legally blind must seek help from the Council for the Blind and, therefore, are not eligible for services provided by Vocational Rehabilitation. Persons eligible for services from the latter agency are those with any visual impairment which substantially affects employment potential. This requirement is flexible, and its interpretation depends heavily on the individual situation. Those who are commonly eligible include:

(1) Persons with imperfectly corrected vision who are limited in the kinds of work they can perform due to poor vision.

(2) Persons with cosmetic defects, such as strabismus.

(3) Persons with only one eye or with a very limited field of vision.

b. Services — Some of the services listed are provided on the basis of need, while others are available to any person who is eligible for Vocational Rehabilitation services. Services include general and special diagnosis, hospitalization, medication, treatment, prostheses, surgery, counseling, work evaluation, personal adjustment training, on-the-job training, vocational training and placement, and maintenance during training or restoration.

3. **Other Agencies, Organizations**

Dozens of other agencies in the community contribute to the desired therapeutic milieu. Service agencies include the Department of Public Welfare, which is the only Florida public agency thus far providing homemaker services; the Crippled Children's Commission; etc. The services normally provided by Public Health nurses should be available to the blind and visually impaired. The aged who are blind may require additional services or transportation to the Health Department. If there are a considerable number of blind persons served by the Department of Public Health, special personnel and services should be provided for this group if they are not adequately served by other agencies and facilities in the community. Organizations include a wide variety of those designated particularly for the blind, those which are available to the blind as well as other disability groups, and civic clubs interested in serving the blind. The community facilities which contribute to the blind and visually impaired are largely the same ones which are important to any community citizens — the library and cultural programs, churches, local news media, etc. All of these play vital roles in the therapeutic community.

D. SUMMARY

The gamut of services mentioned in this chapter are geared toward helping create a healthy, productive, "whole" person capable of participating in community activities and becoming a contributing worker rather than a client.

CHAPTER III
WORK-ORIENTED FACILITIES

A. PURPOSE OF THE CHAPTER

This chapter will deal with the multiple-service agency for the blind. This type of facility provides for or obtains elsewhere a full range of vocational services needed by the blind.

B. REASONS FOR HAVING A WORK-ORIENTED FACILITY FOR THE BLIND ONLY

Sight is one of the most important senses in work-oriented facilities which serve persons with various kinds of handicaps. While blind persons can perform almost any task by relying on the sense of touch, they generally require more time to develop work skills, and their production rate may be slower. In workshops which provide employment for different disability groups, there are often several jobs which a blind person can perform at the regular production rate; however, little thought is given to using the blind for these more appropriate jobs. Facilities that are most successful in dealing with the blind are planned to serve primarily the blind. They are staffed by persons familiar with the problems of the blind and are experienced in working with the blind. Of course, such a facility employs people with other types of handicaps to do jobs which require sight.

C. TWO BASIC SYSTEMS OF OPERATION

The work-oriented facilities described in this chapter might be operated in one of two ways — by the State of Florida or by a private non-profit organization.

1. State-Operated Facilities

If these facilities were operated by the state, the responsibility for them would undoubtedly be assigned to the Florida Council for the Blind. The Council has the authority to operate workshops, although it has never exercised this authority. Further special legislation would probably be necessary in order to obtain sufficient freedom of action to operate this kind of facility successfully. Of course, sizable appropriations would be necessary and this might present a problem.

2. Private, Non-Profit Operated Facilities

The private, non-profit operated work-oriented facility is considered preferable in Florida if communities can be successfully encouraged to establish the facilities which are needed. The system of state operation should be used only if this system fails to serve the blind adequately. Several aspects of the private non-profit system of operation should be considered.

a. **Local Interest** — The private non-profit operated facility springs up in a community as the result of community interest, and it is likely to be successful because of local interest. While local leaders must assume responsibility for planning, developing, and continuing the financial support of the facility, the state agency can do a great deal to create local interest, to encourage and help the sponsoring group, and to help support the facility by purchasing services from them.

b. **Board of Directors** — Each facility should have a local board of directors, and representatives from the various local boards should make up part of the state board of directors. Both the local and state boards of directors should include members who represent labor, industry, public relations, and other areas of interest as well as rehabilitation. A statewide advisory committee composed of persons of various professions should also be appointed. This arrangement should promote interest and growth in the entire program.

c. **Funds** — Local funds are necessary to serve as seed money for matching grant funds. Because the facility must conform to the regulations of the Wage and Hour Department of the U. S. Government, and because it is likely to have a low production rate, such a facility seldom produces enough income to cover all its expenses. Therefore, additional local funds are necessary to maintain the facility operation. These funds may be secured from United Fund, the city and county government, and personal contributions. Such funds should be used to subsidize the rehabilitation aspect of the facility, not the production aspect.

3. Delineation of Roles

Regardless of which of the above types of operation is used, there should be a central coordinating office. In the case of state-operated facilities, this office would be the Council for the Blind. In the case of the private non-profit facilities, it would probably be a state-wide non-profit, chartered board of directors. In either case, the roles of the coordinating office and of individual facilities should be clearly defined.

a. Functions of the Coordinating Office

(1) Establishing the geographical area to be served by each facility

(2) Assisting each local agency in determining what items its workshops will produce

(3) Coordinating sales plans in regard to the territory to be covered, the interchange of products, and sales methods

(4) Supervising the manner in which larger facilities render to the clients of smaller facilities those services which the smaller facilities cannot provide

b. **Functions of the Individual Facilities**

(1) Employing personnel to meet standard requirements[1]

(2) Obtaining local funds, both for capital investment and on-going operation

(3) Maintaining up-to-date records on all fiscal matters

(4) Arranging for all purchases

(5) Managing all the details of the workshop operation

(6) Handling sales

(7) Providing work evaluation, personal adjustment training, prevocational training, occupational training, and other services mentioned later in this guide.

D. TWO TYPES (SIZES) OF WORK-ORIENTED FACILITIES

Two types, or sizes, of work-oriented facilities are recommended to provide ideal rehabilitative services for the blind and visually impaired. The larger type may be called a "regional" facility within the state, and the smaller type may be called a community or local facility. Actually the regional facility is also a community one, but it will provide certain services for persons outside its community.

1. The Regional Facility

a. **Size** — This type facility should be large enough for the workshop operation within it to employ approximately sixty to one hundred people. If too few blind persons live in the community to merit a facility this size, then the community should plan for the smaller type facility or utilize services outside the community.

b. **Services Provided** — This facility should provide the following services:

(1) Nursing services (for emergency treatment)
(2) Psychological services
(3) Social services
(4) Recreational services
(5) Vocational services
    (a) Work evaluation
    (b) Personal adjustment training

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[1] Rehabilitation Services Administration, *Standards for Rehabilitation Facilities and Sheltered Workshops.* (Washington, D.C.: Department of Health, Education, and Welfare, 1967).

(c) Prevocational training
(d) Vocational counseling
(e) Occupational training (Occupational training is currently provided by the Council for the Blind's vocational training center at Daytona Beach. It is adequate at this time, and the regional facilities may utilize it. However, in the future when this center is no longer able to meet all the needs for vocational training of the blind, training units should be established in the regional facilities.)
(f) On-the-job training
(g) Transitional employment
(h) Extended employment
(i) Placement and follow-up services

(6) Residential services (Clients from smaller facilities will be going to the regional facility for a brief time in order to receive specific services, and arrangements should be made for their residential accommodations. The facility may either provide these accommodations itself or enter into an agreement with a local boarding house or motel whereby clients may reside.)

c. **Personnel Needed**

(1) Manager or administrator
(2) Production superintendent
(3) Foreman (One foreman for each fifteen workers)
(4) Contract procurement specialist
(5) Public relations specialist (Part-time)
(6) Sales manager
(7) Secretarial and clerical staff as needed
(8) Librarian (Part-time)
(9) Nurse
(10) Director of home industries (Should have a degree in industrial arts and experience in working with the handicapped, teaching, or working in a work-oriented facility.)
(11) Psychologist (Part-time)
(12) Director of social services
(13) Social worker
(14) Recreational therapist
(15) Rehabilitation counselor (To be supplied by the Council for the Blind)
(16) Work evaluator (One for each ten persons in work evaluation at any given time)
(17) Personal adjustment teacher (One for every twenty

persons in personal adjustment training at any given time)
(18) Vocational skills instructor
(19) Occupational therapists

d. **Suggested Locations** — Regional facilities might well be located in Ft. Lauderdale, Jacksonville, Miami, Pensacola, St. Petersburg, Tampa, and possibly Sarasota. These are suggested areas; the selection of the city itself should depend on the degree of local interest and readiness for developing the facility and also on the number of blind and visually impaired in the area.

2. **The Local Work-Oriented Facility**

a. **Size** — The size of this facility would not be as large, since fewer services will be rendered and it will serve fewer clients. The facility should be large enough to provide employment for a minimum of thirty and maximum of forty-five persons.

b. **Services Available through Regional Facility** — The local facility will obtain certain services from the nearest regional facility. Ordinarily the client will go to the regional center for these services, although in some cases personnel from the regional facility will visit the local facility. The services provided to local facilities by a regional one include:

(1) Psychological services
(2) Social services
(3) Work evaluation
(4) Personal adjustment training
(5) Occupational training
(6) Nursing services
(7) Social services

c. **Services Provided by the Local Facility**

(1) Social services
(2) Recreational services
(3) Vocational counseling
(4) Transitional employment
(5) Extended employment
(6) On-the-job training
(7) Home industry services (If in sufficient demand)
(8) Placement services

d. **Personnel Needed**

(1) Manager or administrator
(2) Production superintendent
(3) Foreman (One for each fifteen employees)
(4) Contract procurement specialist
(5) Sales manager
(6) Social worker

(7) Recreational therapist (Perhaps only part-time)
(8) Vocational counselor
(9) Secretarial and clerical staff
(10) Director of home industries (If the need for home industries is great enough to merit an additional staff member)

E. SPECIAL CONSIDERATIONS FOR EITHER SIZE FACILITY

1. Location

The facility should be located in an area accessible to public transportation. The area should be well-equipped with sidewalks, because a blind person cannot navigate himself successfully where no sidewalk exists. In order to stimulate general public interest, the facility should be located so that it is easily accessible to the public. Also, the aspect of how manufactured products will be shipped and purchases received should be considered in selecting a location.

2. Safety Features

a. **Steps** — A loose swinging gate should be placed at the top of steps and stairs.

b. **Ramps** — A ramp with a rail on each side is preferable to steps where it is possible to install a ramp.

c. **Traffic Buttons** — Modern manufacturing plants paint lines on halls and walkways to direct the flow of traffic, while manufacturing plants employing the blind usually mark traffic lanes with small traffic buttons on the floor. Buttons about one-third the size of regular traffic buttons used on streets are placed along the sides and down the center of the walkways. These walks are used for driving small hand trucks as well as for walking; therefore, the buttons should be placed close enough together to guide the blind, but far enough apart for the wheels of a hand truck to pass between them when the truck enters or leaves a lane.

d. **Railings** — After the physical plant is constructed and equipment has been installed, railings should be placed around each piece of equipment so the blind will not walk into the equipment.

3. Space

The building should be large enough to provide ample space for the following purposes:

a. Office space for each member of the administrative staff, professional staff, and secretarial and clerical staff

b. A conference room with a long table and sufficient chairs for the entire staff (An accordion-type divider might be used to divide the room when a smaller meeting room is desirable.)

c. Work evaluation department

d. Contract manufacturing department

e. Prime manufacturing department

f. Storage space for both raw and finished goods

g. Shipping and receiving areas

h. Lunchroom and kitchen area

i. Recreation space (This ought to be a large area equipped with accordion-type dividers to separate it into smaller areas.)

j. First aid room

k. Wash rooms and locker rooms.

4. **Equipment**

a. Work Evaluation Equipment — The equipment used in a work evaluation unit depends on the aims of the particular unit, and the equipment varies widely according to the job samples and specific tasks which have been selected. The equipment for work evaluation should be selected by the work evaluator with the assistance of other staff members and the supervision of vocational counselors from the Council for the Blind.

b. Training Equipment — A client who is to remain in the facility to work or is to move into competitive employment should be trained to use the equipment he will be expected to use later. Therefore, it is advisable to place in the training area a sample of every major piece of equipment which will be used in production by the trainee.

c. Equipment for Prime Manufacturing — The type of equipment needed for prime manufacturing will depend solely on what items are to be produced. All of the equipment should be of the latest model and have all the most recent safety features. Care should be taken to purchase a sufficient number of each type of equipment for maximum production. For example, one operation may be performed in half the time required for another operation, so that two pieces of equipment are needed for the latter job, but only one for the first job.

d. Equipment for Contract Work — If a facility is going to participate in sub-contract work, it should survey industries with potential contract work in order to determine the types of contracts which can be anticipated. The basic equipment must be purchased prior to actually obtaining a contract, so that tests can be run to help estimate production costs, and in order to avoid the ordering of equipment later and having to wait for it. In some cases the contracting industry will furnish the equipment needed and will even engineer the production set-up.

F. SPECIAL FUNCTIONS IN THE FACILITY

Although the primary purpose of the work-oriented facility is rehabilitation, its operation is a business. It must be operated on sound principles and practices.

1. The Home Industry Program

a. **Eligibility** — The home industry program is available to a person who:

(1) Is unable to travel to the facility daily due to prohibitive distance

(2) Is unable to work in the facility due to multiple handicaps

(3) Has family responsibilities which require him to remain in the home

(4) Is able and willing to devote at least three hours of work a day to home industry

(5) Has space in the home where he can work without interference.

b. **Operation**

(1) The home worker is trained to produce the items he is to make. These may be items for either prime manufacturing or contract work. The equipment to be used is usually taken to the home and the worker trained in its use there.

(2) All equipment will be supplied by the facility, unless the Council for the Blind will supply it. Some equipment will require a special electrical outlet. In such cases this should be installed at the expense of the facility.

(3) Payment for work is on a piece basis. The facility should contact the Department of Labor for information on establishing acceptable methods of keeping records of work hours and production.

(4) The facility will assume all responsibility for sales.

(5) The facility will establish regular dates to pick up the work produced by the home worker and to deliver raw materials for further production.

2. The Work Evaluation Unit

a. **Evaluator's Relationship to Counselors and Workshop Staff** — The work evaluation unit should supplement other vocational services provided by the Council for the Blind, and evaluators should work closely with the counselors in conducting an evaluation and developing plans for a client. If on-the-job training, extended employment, or personal adjustment training is recommended, the evaluator should consult with the appropriate facility staff member. If outside placement is recommended, he should consult with the vocational counselor who would be responsible for helping the client find employment.

b. **Records** — The evaluator should maintain comprehensive records on each client as the evaluation progresses. At the end of the evaluation he should prepare a carefully written, detailed report on the client's capabilities and skills, his weaker and stronger areas, personality factors, etc., and make specific recommendations.

3. **The Contract Department**

a. **Costs** — In obtaining contracts, every effort should be made to secure accurate cost figures. A number of expenses such as manufacturing costs, labor, Social Security, insurance, sick leave, vacation leave, etc., enter into the cost of the item being produced. Labor costs should be based as nearly as possible on manufacturing labor costs in the geographical area where the facility is located.

b. **Percentage of Workers in Contract Department** — Contract work should not involve more than fifty per cent of the blind employees in the facility, meaning that at least half of them should be in prime manufacturing.

c. **Number of Contracts** — If at all possible, contract production should be based on business with two or more manufacturers.

4. **The Prime Manufacturing Department**

a. **Survey of Industry** — The local Chamber of Commerce should be contacted to determine whether or not a survey to bring industry to a given community has been conducted. If so, a copy of the survey will be helpful. If not, a few of the leading manufacturers and merchants in the area should be interviewed to obtain an idea of potential products. This must be done prior to constructing the physical plant in order to plan for adequate space for manufacturing and for storing raw materials and finished products.

b. **Manufacture of Products for the Government** — One type of prime manufacturing is the production of items for the federal government. This business is allocated to facilities for the blind by National Industries for the Blind of New York, which is responsible for implementing Public Law No. 41, Public Contracts, better known as the Wagner O'Day Act. According to the Wagner O'Day Act, in order for a workshop to produce an article for the federal government and sell it as a blind-made product, seventy-five percent of the work on the article must be performed by blind persons. This is an additional reason for establishing workshops for the blind only. In selecting items which the work-oriented facility will produce for the federal government, consideration should be given to the type of equipment necessary to manufacture each item and whether or not this same equipment could also be used to produce articles for civilian business.

c. **Percentage of Prime Manufacturing Done for Government** — The amount of business performed for the federal government should not exceed fifty percent of the total production of the prime manufacturing department. There are great peaks and valleys in government business from time to time; therefore, a more stable production schedule can be maintained if it is not entirely dependent upon contracts from the government.

5. **Records**

a. **Client Records** — A complete case record of each client shall be maintained by social service and be available to the staff as necessary. Records should reveal the client's progress, adjustment, and capabilities. These records should reflect the need for a change of work, additional training, or placement outside the workshop. The client's records should be reviewed every ninety days by the foreman, the work evaluator, and the rehabilitation counselor.

b. **Cost Records** — A cost analysis of the production of each item produced in the shop should be kept up-to-date and reviewed frequently. These analyses are the responsiblity of the production supervisor.

c. **Price List** — A current, printed price list of items should be available for salesmen and customers.

d. **Sales** — The sales plan developed should depend largely on the types of articles produced and the kinds of customers who might be interested in these articles. The sales manager should make detailed monthly reports on sales to the executive director.

e. **Certificates and Pay Records**

(1) **Competitive Rates** — Regardless of the method used to figure pay, rates should be based on the current rate paid for similar types of jobs in the competitive labor market of the area.

(2) **Minimum Hourly Rates** — Operations for which clients cannot be paid by the piece should be based on a minimum wage unless the client's production is high enough to earn more than the minimum hourly rate.

Many of the clients who are paid the minimum will not actually earn that amount. Distributing raw materials and picking up finished products are examples of tasks for which clients cannot be paid on a piece-work basis.

(3) **Certificates and Remuneration** — The schedule of payments to clients must be based on the Department of Labor's regulations for work-oriented facilities. This involves obtaining a sheltered workshop certificate to permit the employment of clients who are paid at the piece-work rate but perform at such a slow rate they cannot earn the minimum wage per hour required by federal standards. Several specific types of certificates of this nature may be issued.

6. Policies

Printed policies should be prepared and distributed to all persons to whom they apply in the work-oriented facility. These should by policies regarding work hours, sick leave, vacation leave, insurance, Social Security, and restrictions pertaining to the physical plant and equipment. The policies should cover both clients and other employees in the shop. The shop should be run like any industry, and no policies should apply to sighted employees which do not apply to blind clients, or vice versa, unless there is some extenuating circumstance which justifies this. The policies should apply to persons in the work evaluation unit as well as those in the workshop.

7. Quality Control

Quality control is the process of seeing that products measure up to acceptable standards. Items should be inspected at certain points in the manufacturing process prior to completion. This eliminates the total loss experienced when inspection is delayed until the product is finished and then defects are found. There have been cases in the past in which agencies employing the handicapped asked for absurd prices for an inferior product. Any agency operated for the employment of disabled persons should be careful to offer the public only first class merchandise at a fair market price. Products should be sold at a price based on their value and the facility's capacity to serve the customer.

G. SUMMARY

Blind persons must usually work in a setting planned for the blind, and this is most frequently a work-oriented facility for the blind. These facilities may be state or privately operated. The three existing ones in Florida, which are located in Miami, Tampa, and West Palm Beach, are privately operated. The work-oriented facility provides a variety of services, with the scope of services depending primarily on the size of the facility. A major part of such a facility is its vocational program, which provides transitional and extended employment opportunities for the blind. The workshop contracts to manufacture certain products for local industries, and it also has larger, extended contracts to produce items for other industries and for the federal government.

CHAPTER IV

SUMMARY

A. COMMUNITY GOALS IN SERVING THE BLIND AND VISUALLY IMPAIRED

In providing ideal services for the blind and visually impaired, communities must set goals which may be difficult to attain. Complete services which prepare the blind and visually impaired for optimum living should be the community's goals.

1. Referral Services

Facilities can reach nearly all of the persons who need their services when the community has an effective referral procedure.

2. Trained Personnel

When the referral system functions properly, the facility can serve all those who need its help if it has the proper number of well trained staff. Lack of financial resources and an insufficient number of persons trained in most areas of rehabilitation limit the number of available staff in some facilities.

3. Active Public Relations

An on-going public education program informs blind and visually handicapped persons where to obtain services, and assures that the general public will cooperate in developing and supporting better services for the disabled. The public relations of any given agency for the blind should be an important aspect of its activity. A large agency might benefit from the services of a public relations firm. When employers are well informed, they will consider the possibility of hiring a qualified blind person and yet avoid placing him in a position for which he does not have adequate preparation or ability. In some communities where only a superficial knowledge exists, employers hire the blind and visually impaired for jobs they cannot do, and they find it extremely difficult to release them from these jobs. Of course, in the long run this is a disservice to the handicapped.

4. Effective Facilities and Programs

It is not good enough to have a program in a facility. It must be an effective program as reflected in high standards for services and staff. The rehabilitation of the blind, as seen in their ability to work, play, and live creative and productive lives, is the direct result of an effective program in a facility.

B. INTERESTED ORGANIZATIONS, CLUBS, PROFESSIONAL PERSONS

Various organizations, clubs, and professional workers of the community must play an important part in contributing to the over-all therapeutic community and in providing all the services necessary for rehabilitation of the blind. Smaller, more limited groups of this type should lay the groundwork for establishing a modern, broadly-based facility and stimulate continuing interest in the community's numerous service programs.

C. THE "WHOLISTIC" APPROACH

At the present time, the majority of the blind population of Florida are dependent on the Florida Council for the Blind's counselors, home teachers, and child guidance personnel for help. However, even with this staff doubled or tripled, it would not begin to provide all the services which the visually handicapped need. In addition to the assistance given them by Council for the Blind personnel, this disability group needs the entire gamut of services provided by clubs, organizations, schools, recreational facilities, churches, businesses, facilities, etc., of the community. All of these contribute toward the ideal environment of the therapeutic community and are essential components of a wholistic approach to treatment. Each individual is a whole person, and he can best be helped when he is treated from this point of view. The blind and visually impaired person has the same basic needs as others; and he, too, must be treated as a whole man in order to develop his maximum potential.

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REHABILITATION SERVICES FOR SPEECH AND HEARING IMPAIRMENTS

IDEAL SERVICES SERIES

VOLUME VI

BY

L. L. SCHENDEL, Ph.D.

U.S. DEPARTMENT OF HEALTH, EDUCATION
& WELFARE
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STATE DEPARTMENT OF EDUCATION

Division of Vocational Rehabilitation
Rehabilitation Facilities Section

Tallahassee, Florida

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FOREWORD

This volume, the sixth of the Ideal Services Series, deals with rehabilitation services for persons with language, speech and hearing problems. It is an outgrowth of the Workshops and Rehabilitation Facilities Planning Project initiated by the Division of Vocational Rehabilitation in July, 1966, and it will be presented as a guide to all persons involved in Workshops and Rehabilitation Planning.

Prior to the twentieth century, there were few services for individuals with language, speech and hearing disorders, except for several special schools for deaf children and the occasional efforts of individual physicians and teachers. Professional identity emerged in the 1920's. University training programs were developed for the preparation of clinicians and researchers and a few speech and hearing services for children were initiated in certain public schools. A professional organization was founded in 1925, which has now become the American Speech and Hearing Association. World War II provided a significant impetus toward professional development. Language, speech and hearing services became an important part of military rehabilitation programs for service men who suffered speech and language impairments or hearing problems resulting from head wounds or exposure to blast. Technological advances in electronics and communication systems produced improved techniques for research and improved methods for assisting children and adults with language, speech and hearing disorders. The professions of speech pathology and audiology should be ready and able to accept the challenge for participation in comprehensive community rehabilitation program.

Rehabilitation — with its ultimate objective of nurturing the handicapped toward or restoring them to useful and satisfying lives — is a true expression of man's humanity to man which is deeply rooted in Judaic-Christian teaching and tradition. Rehabilitation has gained a gratifying level of public understanding, acceptance and support. We no longer need to convince one another of the merits of rehabilitation.

But, now we face a more significant challenge — the difficult task of creating a rehabilitation orchestra — the difficult task of shaping a company of professional performers, playing different professional instruments into the kind of harmonious integrated unit which the rehabilitation of the handicapped requires.

The concept of comprehensive community rehabilitation services demands that the speech and hearing specialist be tuned to the part he plays in the symphony of rehabilitation. The role of the speech and hearing specialist is to provide preventive, evaluative, and treatment services to handicapped fellow human beings, in cooperation and harmony with other rehabilitation personnel, with the ultimate objective of nurturing the handicapped toward or restoring them to a life as happy and productive as modern treatment methods, nature, and nature's God will allow. As professional specialists understand one another and work together, the symphony of rehabilitation becomes a gratifying and beautiful thing to behold!

ABOUT THE AUTHOR

L. L. Schendel received the Ph.D. in Speech Pathology and Audiology from Northwestern University, Evanston, Illinois, in 1958. He served as the chairman of the Division of Speech Pathology and Audiology at Florida State University from 1954 until 1968. He is currently serving as head of a newly reorganized academic department at Florida State University, including the training programs in special education, rehabilitation counselor training, speech pathology, audiology, and deaf education. Other professional teaching experiences have been at the University of Oklahoma, Colorado State College, Northwestern University, and Louisiana State University.

L. L. Schendel, Ph.D., is a Fellow of the American Speech and Hearing Association and holds the Certificate of Clinical Competence in Speech Pathology awarded by the American Speech and Hearing Association. He is a member of the professional advisory committee of the Florida Society for Crippled Children and Adults, a consultant in Speech Pathology to the Florida Crippled Children's Commission, a member of the State Advisory Committee for Exceptional Child Education, a consultant in Speech Pathology and Audiology to the Florida Division of Vocational Rehabilitation, and a past president and member of the board of directors of the Tallahassee Easter Seal Rehabilitation Center. He is a member of the Florida Speech and Hearing Association, the American Speech and Hearing Association, and the American Association on Mental Deficiency.

ACKNOWLEDGEMENT

An undertaking of this kind reflects the influence and cooperation of many persons and experiences. The philosophical and conceptual bases for these guidelines have evolved from conversations and meetings during the past two years with the members of the panel of State Consultants to the Florida Division of Vocational Rehabilitation.

The author extends appreciation to the many professional colleagues in Speech Pathology and Audiology in the State of Florida who read the manuscript and made helpful suggestions and corrections or who provided guidance and advice concerning content. The help and influence of the following persons merits a special acknowledgment: Dr. M. M. Meador, Audiologist, Florida State University; Dr. Robert J. Harrison, Audiologist, Dr. Duane Logue, Speech Pathologist, and Dr. Betty Phillips, Speech Pathologist, University of Miami Medical School; Dr. Clarence Webb, Speech Pathologist, University of South Florida; Dr. Lowell Hammer, Speech Pathologist, Dr. Tom Abbott, Speech Pathologist, and Dr. Paul Moore, Speech Pathologist, University of Florida; Dr. Sara E. Conlon, Consultant, Speech and Hearing, Florida State Department of Education.

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L. L. Schendel, Ph.D.

ENDORSEMENT

It has been my pleasure to review *Ideal Services Series: Rehabilitation Services for Speech and Hearing Impairments.* You are to be congratulated on the knowledgeable and practical way you have dealt with a multifaceted problem. The volume can serve as a guide to anyone interested in establishing service facilities for the communicatively handicapped.

I not only endorse your volume, but offer my congratulations to you and appreciation for your significant contribution to the fields of speech pathology and audiology and rehabilitation counseling.

Robert J. Harrison, Ph.D.
Director
Audiology-Speech Pathology
School of Medicine
University of Miami

CHAPTER I
INTRODUCTION

A. PHILOSOPHY

It has been the philosophy of the Division of Vocational Rehabilitation that services for disabled individuals can best be provided by communities participating in the development, improvement, expansion and control of rehabilitation facilities and workshops. It is felt that community ownership and operation of facilities offers more strength and support than state agency ownership and operation.

B. PLANNING FOR FACILITIES

Vocational Rehabilitation began the development of a plan for workshops and facilities in 1966. From the beginning of this planning effort, Vocational Rehabilitation has developed resource materials which would aid communities in developing services for the disabled through facilities. Among these materials has been an informational pamphlet, a slide-tape presentation, a survey of facilities, a prevalence study of disabled persons, a compilation of resources for the development of workshops and facilities and a series of publications which present ideal services for various groups of the disabled population. The survey materials indicated what services exist in facilities; the prevalence points out the number of persons who may need rehabilitation services; the resources are some means whereby needs for the disabled may be met; and Ideal Services Series sets forth the goals for which communities should plan.

C. PURPOSE

This volume is not a standard that must be followed. Its purpose is to describe "ideal services" which should be planned by a community for the facilities which serve persons with speech and hearing impairments. With the completion of the Series, information will be available whereby a community should know the services necessary for a comprehensive community rehabilitation program.

D. IDEAL SERVICES SERIES

This publication is only one of the volumes in the Ideal Services Series. Other volumes in the Series are: *The Comprehensive Rehabilitation Center*, etc.; *Mental Health Rehabilitation Services; Rehabilitation Services for the Mentally Retarded; The Work-Oriented Rehabilitation Facility;* and *Rehabilitation Services for the Blind and Visually Impaired.* Future publications in the Series will be: *Work Evaluation; Personal Adjustment Training;* and *Rehabilitation Services for Respiratory Impairments*; and others.

E. DEFINITION OF THE DISABILITY GROUP

Unemployment, under employment and poor social adjustment are frequently found among persons with communication problems. The profession of Speech Pathology and Audiology is concerned with the individual's inability to communicate effectively due to specific language, speech or hearing problems. These specific problems are described as follows:

1. Language and speech problems related to neurological disorder. That is, aphasia, cerebral palsy, bulbar palsy, laryngeal paralysis, stroke, etc.
2. Voice Problems – laryngectomy, hoarseness, loss of voice, nasality, abnormal pitch.
3. Stuttering (stammering).
4. Articulation Problems — difficulty in production of speech sounds which interferes with intelligibility of speech.
5. Cleft Palate speech problems and other maxio-facial and dental disorders.
6. Problems of the deaf and hard of hearing.
7. Language — linguistic problems.
8. Speech and language problems associated with mental retardation.

F. NEEDS OF THE DISABILITY GROUP

1. The Division of Vocational Rehabilitation recognizes that a person who does not speak well or hear adequately may be limited in employability. Communication deficiencies reduce the individual's social and economic participation in society. Consequently, his full potential as a contributing and productive member of society is lost.
2. There is need for early recognition and identification of communication problems in order to initiate appropriate referral and services.
3. Need exists for the development of appropriate speech and hearing rehabilitation programs within the State of Florida.
4. Need exists for implementing periodic follow-up and re-evaluation programs. Such follow-up is essential for measuring the results of rehabilitative procedures.

CHAPTER II
REHABILITATION FACILITIES

A. PHYSICAL FACILITIES

Facilities for Rehabilitation Services are an integral part of the overall clinical program and relate to the effectiveness of the rehabilitation process. Not only do poor facilities minimize motivation of the clinician but the motivation of the clients is similarly effected. Facilities for evaluative and treatment services in speech pathology and audiology may be as variable as those used by physicians. Facilities and services vary from individual work with homebound patients, to the private office with one or several speech pathologists and audiologists, to the community rehabilitation center, to the hospital center, and to the university speech and hearing centers. However, every service program in speech pathology and audiology has certain minimal features in common. Despite the variability in work setting, a rehabilitation center must meet certain minimum requirements.

The American Speech and Hearing Association maintains a professional services board which has been established to provide the evaluation of clinical service programs in speech pathology and audiology. The professional services board has prepared a publication entitled "Registration of Professional Services in Speech Pathology and Audiology."[1] The purpose of the Professional Services Board is to determine the qualifications of speech and hearing service programs which apply for approval and registration of services. The publication mentioned above includes guidelines for administration, staff, community and professional relationships, clinical procedures, supervision, records and reports, and physical plant and equipment. Persons planning rehabilitation services will find this booklet helpful in addition to the present publication.

"The physical plant should be suitably constructed, arranged, and maintained in order that the patient may be furnished effective professional services under conditions of maximum efficiency, safety, comfort, and privacy."[2] In providing for physical space, attention should be given to the size of the area, sound treating, privacy, illumination, ventilation, temperature and general attractiveness.

1. Space, Size and Location

Services in speech pathology and audiology should be located away from sound, vibrations, and passing traffic within the building. When the speech and hearing facility is located within a building providing other services, the speech and hearing rooms might be located at the end of a dead-end corridor. *The need for locating speech and hearing services within relatively quiet environments cannot be overemphasized.*

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[1] *Registration of Professional Services in Speech Pathology and Audiology*, Professional Services Board of the American Board of Examiners in Speech Pathology and Audiology, American Speech and Hearing Association, 9030 Old George Town Road, Washington, D. C., December, 1965.

[2] *Op. Cit.*, page 22.

The speech pathology services will require one evaluation and training room consisting of approximately 200 to 250 square feet. An ideal situation will provide an adjoining office space for the speech pathologist consisting of approximately 192 square feet.

The audiological services will require one office consisting of 192 square feet, one testing and evaluation room consisting of approximately 375 square feet, and one education and training room consisting of approximately 240 square feet. These testing and evaluation rooms should be designed in a way which will permit installation of a prefabricated soundproofed room such as discussed in Chapter V — Equipment. Planning should include adequate space for storage and adequate space for a workshop if calibration and repair of equipment is to be provided within the center.

The speech pathology and audiology services will also require space for secretarial help and space for files and records. The above indicates the minimal space requirements for one speech pathologist, one audiologist, and one secretary. If additional employees are involved, the space needs will have to be increased accordingly. If the client waiting area is to be located adjacent to the speech pathology and audiology services, this need will have to be taken into consideration. In a comprehensive rehabilitation facility, waiting room area may be shared with other services.

2. Lighting

The areas should be adequately lighted. Artificial lighting should provide at least sixty to seventy-five foot candles. If natural lighting is used, windows should be high enough to eliminate distracting stimuli and should be equipped with window shades or drapes. The audiological testing and evaluation room should be windowless and equipped with adequate lighting preferably incandescent rather than florescent.

3. Heating and Ventilation

Adequate thermostatic controlled heating and air-conditioning must be provided for year around operation.

4. Acoustical Treatment

Consideration should be given for acoustical treatment of all ceilings, doors and walls. Ideally, draperies should be provided and floors carpeted. If considerable hall traffic is anticipated, hallways should be carpeted. All rooms, especially the audiological suites, should be constructed so as to eliminate environmental noise transmission. The audiological testing and evaluation rooms should be equipped with a prefabricated soundproofed room.

5. **Electrical Power Supply**

At least one 110 volt double outlet should be installed on each wall. The audiological testing and training rooms should be provided with sufficient electrical outlets to accommodate multiple testing equipment. Electrical outlets for group hearing aids might be required on the floor, at the blackboard and at desks.

B. TYPES OF FACILITIES

Comprehensive community rehabilitation planning should take into consideration local, regional and state facilities both public and private. During the past two years, the Division of Vocational Rehabilitation of the Florida State Department of Education has been conducting a statewide study of the needs for rehabilitation facilities and workshops and for the development of these facilities. One of the high priority recommendations evolving from the State Plan was the need for establishing four regional comprehensive evaluation centers for persons with speech and hearing impairments. The State Plan also revealed an outstanding need for a full range of services in each of the sixteen districts operated by the State Division of Vocational Rehabilitation. This full range of services included speech and hearing. The Division of Vocational Rehabilitation has estimated the need for one speech pathologist and one audiologist per 50,000 population providing a strong speech and hearing program is operating in the public schools.

1. **Regional Comprehensive Evaluation and Treatment Centers**

It is recommended that the regional comprehensive evaluation and treatment centers should be university affiliated. These regional university affiliated centers could help to fulfill three vital needs. First, provide the State of Florida with adequately staffed and equipped regional centers for competent comprehensive evaluation and treatment of the speech and hearing handicap. Second, provide enriched teaching programs for the professional personnel needed for staffing community speech and hearing facilities. Third, provide the opportunity for cooperative research into the nature, effect, and rehabilitation of handicapping conditions.

These four regional comprehensive speech and hearing centers have been given a high need priority rating. It is suggested if more than one university in a geographical area applies, selection will be made on the basis of comprehensiveness of the proposed program, the adequacy of funds, initial and on-going support, geographical location, and the availability of trained staff. The university setting is recommended in order to take advantage of the already available potential for a multidisciplinary approach to clinical service, teaching and research involving handicapped persons.

Comprehensiveness of the evaluation and treatment of the speech and hearing handicapped persons should be planned in order to guarantee to the disabled individual the opportunity for maximal attention in acquiring the potential of which he is capable. Attention should be given to provide the following services, in addition to speech pathology and audiology, in the regional comprehensive evaluation and treatment center: Rehabilitation counseling, psychological evaluation, remedial reading services, social work services, music therapy services, special education services, counseling and guidance, and medical evaluation.

Adequate comprehensive diagnosis and evaluation is time consuming. Testing and evaluation are fatiguing upon a client. Consequently, it is assumed that clients will have to be available for several days or a week or more. Recognizing this need, the regional comprehensive evaluation and treatment centers should make plans for housing of clients. Housing arrangments will also have to be made for those clients needing treatment at the regional center in those instances in which treatment facilities are not available in the home or local community.

The regional comprehensive evaluation and treatment facilities should be staffed and organized to provide maximum comprehensive evaluation and intensive treatment including residential accommodations.

2. Local Outpatient Facilities

The State Plan for each of the sixteen districts within the State Division of Vocational Rehabilitation provides for a full range of services including speech and hearing. It is felt that each of the sixteen districts needs at least one speech and hearing facility providing outpatient services to the handicapped adult. These community outpatient speech and hearing services may be provided in conjunction with local hospital centers, Easter Seal facilities, community rehabilitation centers, or other types of community arrangements including private practice.

The purpose of the local community speech and hearing service is to provide routine evaluation and treatment. The facility should be organized and staffed to enable handling of the full range of language, speech and hearing problems. The local speech and hearing facilities are in a most favorable position to provide guidance and information toward prevention of communication disorders, to provide general educational programs, and to work with rehabilitation counselors and other agency personnel in the early identification of persons with various kinds of language and hearing problems.

3. Public School Facilities

A comprehensive program for exceptional children and youth (including speech and hearing handicaps) is based on a sound county-wide screening and diagnostic program with provisions for continual evaluation of pupils placed in special education programs. The public school planned programs begin with the primary level and extend through the high school. However, consideration is given to the development of preschool programs for children with those disabilities where preschool instruction is vital in the educational development of the child. Deaf and hard of hearing children fall into this category. The public school program gives consideration to providing services in facilities operated by other state agencies. Florida statutes pertaining to exceptional child education programs provide for employment of a teacher for each group of ten or more exceptional children between the ages of three and five who have been identified as needing special instruction or services because of deafness or other handicaps. Special approval may be obtained from the State Department of Education for a unit with fewer than ten but not fewer than five pupils in this age group. Special guidelines and regulations pertaining to the county plan for the provision of special education programs for children with speech and hearing problems has been published and is available to planning personnel.[1]

Florida statutes provide for itinerant speech therapy services for children with speech defects who are enrolled in other classes; itinerant instruction including auditory training, language development, speech training and lip reading for children enrolled in regular or special classes who are deaf or hard of hearing; and itinerant instruction in English language for non-English speaking pupils to enable them to learn in regular classes.

State law permits the establishment of special instructural units for exceptional children from state funds. "When the allotment of state exceptional child units is made, consideration is given to the community need for instructural programs for exceptional children as outlined in the county plan and to the availability of approved teachers in the classification of exceptionality in which the teaching is to be done."[2] The general county school speech and hearing program includes screening, identification, evaluation, and treatment of children with various kinds of language, speech and hearing problems which may interfere with educational adjustment and achievement.

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[1] *Guidelines, county plan for the provision for special education programs for exceptional children and youth*, Florida State Department of Education, Tallahassee, Florida 1968.

[2] *Op. Cit.* Introduction

4. **Private Practice in Speech Pathology and Audiology**

In certain communities the usual evaluative and treatment services for persons with speech and hearing problems may be provided by private practitioners. *The qualifications of the person offering private services in speech pathology and audiology should be investigated.* The minimum requirements are the Master's degree or equivalent in speech pathology and/or audiology and the Certificate of Clinical Competence in speech pathology and/or audiology awarded by the American Speech and Hearing Association.

5. **State Schools for the Deaf**

For many persons of school age, the usual academic and vocational instruction is being provided for the deaf in the State School for the Deaf in St. Augustine, Florida.

C. SUMMARY

Planning for comprehensive community rehabilitation programs should make provision for adequate physical facilities for speech and hearing services. Planning also should consider the types of speech and hearing services available at the local, regional and state levels. Effective utilization and expansion of existing facilities should be considered wherever possible before new facilities are planned in order to avoid expensive duplication. The State Plan of the Division of Vocational Rehabilitation concerning speech and hearing services in the State of Florida has recommended the establishment of four regional comprehensive evaluation and treatment centers, possibly university affiliated, for persons with speech and hearing problems. It also recommends that each of the sixteen districts operated by the State Division of Vocational Rehabilitation provide a full range of services including speech and hearing. Community planning should also give attention to the development of public preschool and regular school services for speech and hearing handicapped children. Effective programs for deaf children should be planned through utilization of the State School for the Deaf or the utilization or establishment of other community programs for the education of the deaf. In certain communities speech and hearing services may be provided by private practitioners.

CHAPTER III
TYPES OF SPEECH AND HEARING SERVICES

The professions of speech pathology and audiology are concerned with problems and disorders of human communication as manifested in the processes of speech and hearing. These professions are devoted to providing clinical services to both children and adults. The spectrum of community speech and hearing services includes the following: Prevention of Speech and Hearing Problems, Early Identification of Persons with Speech and Hearing Problems, Evaluation of the Causes and Nature of Speech and Hearing Problems, Treatment to Meet the Needs of The Speech and Hearing Handicap, Recording and Filing of Data Relating to the Speech and Hearing Handicap, Routine Followup, and General Community Educational Programs. The kinds of communicative problems the speech and hearing services are designed to deal with are defined in Chapter I, Section E.

A. PREVENTIVE PROGRAMS

Prevention is a more enlightened approach to community welfare than cure or treatment. The professions of speech pathology and audiology have developed to the point where they now can take effective steps toward the prevention of some speech and hearing problems.

A preventive program might well be coordinated with a general public information program. An educational program providing information concerning the nature of language and speech development may make considerable progress in the prevention of stuttering. Early and effective attention to ear, nose and throat problems may aide in the prevention of hearing loss or voice problems in certain persons. Early and effective team approach to the fulfillment of the needs of children born with cleft lip and palate may prevent the development of certain types of voice and articulation disorders in this population. The identification of deaf infants through an infant testing program and the early initiation of effective habilitation programs for deaf and hard of hearing infants could make considerable progress toward the prevention of some of the educational and vocational problems which these persons normally encounter. Effective noise control programs in industry may aide in the prevention of noise induced hearing loss. The establishment of effective public information programs concerning the causes and consequences of speech and hearing problems and the taking of steps to prevent the development of communication disorders are reasonable community responsibilities. The community speech and hearing personnel should be involved in guiding the fulfillment of these responsibilities.

B. IDENTIFICATION PROGRAMS

There is need for early recognition and identification of communication problems in order to initiate appropriate referrals and to institute appropriate rehabilitation procedures. In many instances, early identification works toward the prevention of more serious speech and hearing problems. There is a need for speech and hearing personnel at the local level to work with rehabilitation counselors, public health workers and others in the early identification and recognition of speech and hearing problems. Speech and hearing personnel may provide workshops for counselors in the Division of Vocational Rehabilitation and for other rehabilitative personnel to acquaint them with the information appropriate to the early identification of speech and hearing problems.

C. EVALUATION AND DIAGNOSIS

Clinical services include the evaluation of the speech and/or hearing impairment by a wide variety of diagnostic procedures. These activities frequently involve cooperative endeavor with many specialists such as physicians, educators, psychologists, social workers, rehabilitation counselors, etc. Effective treatment programs are dependent upon competent and comprehensive evaluation. Prognosis and the recommendations for specific rehabilitative procedures should be based on comprehensive diagnostic information. Diagnostic information should be communicated effectively in order to establish a coordinated approach to the problems of the client. Diagnostic findings should serve as the basis for referral to other specialists, when necessary. Procedure for review of diagnostic findings should be established.

D. TREATMENT PROCEDURES

Rehabilitative procedures for the speech and hearing handicapped should be based upon a realistic conception of the ultimate goals the client can be expected to achieve. These goals should reflect the limitations suggested by the evaluative information. The rationale for rehabilitative procedures should reflect the needs of the client and the nature of the problem he presents. The speech and hearing clinician must assume responsibility for evaluating the reactions of the client to treatment procedures, for evaluating the client's progress, for obtaining guidance and consultation when necessary, and for utilizing the team approach to rehabilitation.

The regional comprehensive evaluation and treatment centers should be organized to provide residential accommodations for clients when needed to guarantee the comprehensive approach to the fulfillment of treatment needs. The regional comprehensive center must be prepared to provide the treatment services not available to clients in their home communities.

It is planned that a full range of speech and hearing services will be available in each of the sixteen districts operated by the State Division of Vocational Rehabilitation. These services could be made available on a day to day outpatient basis. Some planning and consideration should be given to providing local community speech and hearing services to the homebound client.

E. CLINICAL RECORDS

An integral part of the services of a speech and hearing facility is the effective maintenance and use of client's records. It is the speech and hearing specialists responsibility to record clinical observations objectively and meaningfully, and to summarize and communicate clinical information effectively. A clinical service program should not attempt to function without an efficient system for data storage and retrieval. Adequate clinical records are essential for meaningful follow-up evaluations. An individual file must be maintained on each client served which should include comprehensive diagnostic and evaluative information, an adequate chronology of services, follow-up procedures, referrals, etc. The confidential nature of all clinic records should be preserved.

F. FOLLOW-UP PROCEDURES

The value of implementing routine periodic follow-up and re-evaluation procedures should not be overlooked. Such follow-up is essential for the adequate measuring of the results of rehabilitation endeavors. Follow-up evaluations by persons initially seen at the regional comprehensive evaluation and treatment centers might be handled more conveniently and economically by the speech and hearing personnel within the clients local community. The speech and hearing clinician is responsible for evaluating the progress of the client and this progress should be evaluated in relationship to the rehabilitative goals established for the client.

G. EDUCATIONAL PROGRAMS

Community education is vital to the success of any speech and hearing program. It should be considered an integral part of any service facility. Much of the community education program can be coordinated with the preventive and identification service programs describe; previously. The community education program should include advisement to business and industry concerning the effective use of speech and hearing disabled personnel and advisement concerning the prevention of speech and hearing job related disabilities. An often times overlooked community educational program is providing for an effective method or procedure for informing the community about the kinds of language, speech and hearing services which are available.

Persons who require speech and hearing services need to know how to go about seeking these services.

H. SUMMARY

An ideal speech and hearing service program involves its speech and hearing personnel in instituting measures which work toward preventing the development of speech and hearing problems, in establishing and maintaining early identification of persons with communicative disorders, in providing effective and comprehensive diagnostic evaluation information, in providing treatment appropriate to the needs and abilities of the clients, in maintaining accurate and meaningful records and files, in carrying out the necessary follow-up procedures, and in establishing and maintaining meaningful community educational programs on behalf of the speech and hearing handicapped.

CHAPTER IV
PERSONNEL

Since adequate comprehensive evaluation and treatment of the problems presented by persons with speech and hearing impairments requires a coordinated and cooperative effort of several professional disciplines, in addition to speech pathology and audiology, community planning should give consideration to the availability of qualified personnel in rehabilitation counseling, clinical psychology, social work, remedial reading, special education, music therapy, rehabilitative recreation, etc. The need for competent medical evaluation and advice is recognized in the field of speech pathology and audiology. The medical aspects of the program must be considered and safeguarded. Plans for rehabilitation facilities contain a guarantee of the professional qualifications of all staff persons.

A. QUALIFICATIONS OF PERSONNEL

The minimal qualifications for speech pathologists and audiologists require training at the Master's degree or equivalent and the certificate of clinical acceptance in Speech pathology and/or audiology. The certification program of the American Speech and Hearing Association is the mechanism by which individual qualification in speech pathology and/or audiology may be established. Staff members who hold the certificate of clinical acceptance awarded by the American Speech and Hearing Association are considered qualified to work independently in the professional area for which they are certified. All uncertified staff members must work under the supervision of certified personnel. The speech pathologist and audiologist functioning in the regional comprehensive evaluation centers should probably be trained at the doctoral level in addition to the certificate of clinical competence; whereas, the speech pathologist and audiologist functioning in the local district treatment centers could qualify at the Master's degree level of training, plus the certificate of clinical competence.

Staff members who represent professional disciplines outside speech pathology and audiology should meet qualification or licensing requirements established by their national or regional professional organizations. Physicians who are used as consultants should be Board approved. Rehabilitation counselors working with the speech and hearing impaired should have some training and experience in the nature and identification of communication disorders and in the ability to communicate effectively with the language and hearing impaired.

B. SIZE OF CASELOAD

If one speech pathologist devotes full time to evaluation, he should be able to handle a weekly caseload of 25 patients. If he restricted his activities to rehabilitative aspects, he should be able to handle approximately 50 to 60 patients per week. If one speech pathologist engages in both evaluation and treatment, the actual caseload would involve some compromise between the above two figures.

The audiologist's caseload would also depend upon the nature of the program. If he devoted his time solely to evaluation procedures, he should be able to handle a caseload of 25 to 30 patients per week and if he restricted his activities to all rehabilitation procedures, he should be able to serve approximately 50 to 60 patients per week. If the audiologist engaged in both evaluation and rehabilitation aspects, the caseload would involve some compromise between the above two figures.

C. DUTIES OF PERSONNEL

The audiologist within the center should provide complete diagnostic and/or evaluative measures appropriate to the problems presented by the client and should provide recommendations for treatment or other disposition. Specific services would include audiological evaluation, fitting of hearing aids, training in the use of hearing aids, training in auditory discrimination and lipreading, and training in the development of general communication skills required for deaf and hard-of-hearing clients. Treatment would be provided when the circumstances dictated.

The speech pathologist in the center should provide complete diagnostic and/or evaluative measures appropriate to the problems presented by the clients, together with specific recommendations for treatment and/or disposition of clients. It is assumed that treatment would be made available for those clients who require it. Evaluative and treatment services should be made available to persons with neurological disorders such as aphasia, cerebral palsy, bulbar palsy, pharyngeal and laryngeal paralysis, stroke, etc; voice problems, stuttering; cleft palate and other maxio-facial and dental disorders.

The duties of other professional personnel would be appropriate to their professional disciplines. Their specific responsibilities to the speech and hearing handicapped would be to provide evaluative information and insight in support of comprehensive differential diagnosis and to provide supportive treatment services on behalf of effective rehabilitation of clients.

D. PROCUREMENT AND AVAILABILITY OF PERSONNEL

Speech pathologists and audiologists, similar to other rehabilitative personnel, are in short supply. Community planning groups should take this fact into consideration and should initiate procurement procedures well in advance of the date the program is to be started. Employers may be aided in finding personnel by contacting the placement offices or the directors of the training programs for speech pathologists and audiologists at colleges and universities. Other sources include the placement services of the American Speech and Hearing Association, the National Society for Crippled Children and adults, and the various state speech and hearing association. The Florida Speech and Hearing Association through its Placement Service maintains an active list of persons seeking employment opportunities and can be of service to employers by publicizing and distributing descriptions of job opportunities available. Help in community planning for speech and hearing services is also available from the Florida Speech and Hearing Association through its committee on Community Services.

E. SUMMARY

In planning for community rehabilitation services, client welfare should be safeguarded through the qualifications of staff members. The quality of the services provided is a direct result of the activities of qualified personnel. Size of caseload should reflect sensitivity to the need for quality service. Heavy demand for the duties of staff members should be clearly understood and delineated.

CHAPTER V
EQUIPMENT NEEDED

"The effective center obtains and operates equipment in harmony with its own objectives, policies, and unique requirements."[1] An important consideration in the purchase of equipment for a speech and hearing facility is the technical competence of the staff personnel to use the equipment correctly and effectively. The administration of a rehabilitation facility should provide for routine servicing of equipment, adequate storage for equipment, and periodic calibration of equipment. Audiometric equipment must be calibrated periodically and a permanent record of calibration data should be maintained. If maintenance and calibration of equipment is to be handled by members of the professional staff of the facility, then appropriate calibration equipment and adequate repair and calibration space must be provided.

A. AUDIOLOGY EQUIPMENT.

The types of audiological equipment necessary are determined by the scope of the services to be provided and by the qualifications of the professional personnel to be employed. Of prime concern in any audiology program is the availability of a quiet testing environment. Sound control is usually accomplished through the purchase of prefabricated soundproof rooms similar to those provided by Industrial Acoustics Corporation. A qualified audiologist will be aware of the needs appropriate to the facility, will know the sources of vendors for this type of equipment, and will be able to provide cost estimates.

1. **Audiological Evaluation Equipment**
    a. Diagnostic clinical audiometer with accessory units for short increment sensitivity index, loudness balancing test, bone conduction audiometry, speech audiometry, and with auxilliary amplifiers and loudspeakers for sound field testing and hearing aid consultation.
    b. Bekesy-type audiometer
    c. Psycho-galvanometric skin reflex testing unit
    d. Phonograph
    e. Variable electronic filters
    f. Professional quality two-channel tape recorder
    g. Four to six speakers
    h. Speaker switching console
    i. 30 to 50 watt amplifier

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[1] Registration of Professional Services in Speech Pathology and audiology, Professional Services Board of the American Board of Examiners in Speech Pathology and Audiology, American Speech and Hearing Association, 9030 Old Georgetown Road, Washington, D. C., December, 1965.

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   - j. Conventional puretone audiometer with air-conduction and bone-conduction circuitry and accessories for narrow band masking.
   - k. Necessary table and chairs for control unit and test unit
   - l. Routine office furniture for audiologist

2. **Education and Training Equipment**
   - a. Adult work table and chairs to accommodate six to eight persons
   - b. Group auditory trainer with eight sets of earphones
   - c. Tape recorder — two-channel professional quality
   - d. Sound movie projector
   - e. Hearing aid storage cabinet
   - f. Tachistoscope
3. **Calibration and Repair Equipment**
   - a. Audiometer calibration unit
   - b. Oscilloscope
   - c. Signal generator
   - d. Necessary hand tools for repair work

B. SPEECH PATHOLOGY EQUIPMENT

The specific equipment appropriate to a speech pathology program is also related to the scope of the program and the special qualifications and interests of the professional personnel. A qualified speech pathologist will be aware of the needs appropriate to the facility, will know the sources and vendors for the type of equipment needed, and will be able to provide cost estimates.

1. High fidelity two-channel tape recorder
2. Specific language and speech diagnostic tests and kits
3. A Language Master and associated stimulus materials
4. An amplifier unit including microphone and earphones
5. Spirometers
6. Magnetic tapes
7. Blackboard and mirror
8. Various therapy materials
9. Programmed instruction equipment
10. Closed circuit television
11. Work tables and chairs appropriate to accommodate one to six persons
12. Office furniture
13. Pixmobile type cart to mobilize heavy evaluation and treatment equipment.

C. SUMMARY

Although the evaluation and treatment of many speech and hearing handicaps does not require the use of extensive and costly equipment, adequate evaluation of some problems cannot be accomplished without the aid of appropriate clinical equipment and materials. Planning for community rehabilitation facilities should take this factor into consideration. Some of the vital audiological equipment is rather expensive and a planning committee should provide for adequate budgeting. The relationship between equipment needed and personnel should not be overlooked. The needs and wishes of the professional personnel should be given high priority when planning the evaluation and treatment program. Program objectives, physical facilities, qualifications of professional personnel, and equipment and materials must all be coordinated in planning for community rehabilitation facilties.

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